

Mental Health and Assessment Tools: Perspectives from Healthcare Workers

Mental Health and Assessment Tools: Perspectives from Healthcare Workers

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A Thesis

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*Use what talents you possess; the woods would be very silent if no birds sang  
there except those that sang best*

*~Henry van Dyke*

## ABSTRACT

**Background:** Research literature suggests that assessment tools are primarily biomedically oriented, prioritizing the assessment of clients'/patients' problems and deficits. Some literature suggests that assessment tools may be improved with the inclusion of psychosocial content and a focus on clients'/patients' strengths and values. There is limited research on healthcare workers' opinions of the assessment tools they use.

**Purpose:** The purpose of this study is to collect data from healthcare workers to see how their opinions on assessment tools may interact with the existing literature.

**Methods:** Healthcare workers of St. Joseph's Healthcare Hamilton were recruited to complete an online survey comprised of 27 questions asking about the assessment tool they use most. Data was then analysed using descriptive statistics.

**Findings:** Participants generally believe that the assessment tools they use are limited in their engagement with strengths, values, and many relevant biopsychosocial issues, and should increase their engagement with these subjects.

**Implications:** Further research is needed to understand if - like the participants of this study - a larger sample of healthcare workers also feel that the assessment tools they use should change the extent to which they address certain issues. Furthermore, research is needed to understand reasons *why* healthcare workers may feel this way.

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## CHAPTER 1: INTRODUCTION

One in five Canadians are estimated to experience mental health issues in any given year (Mental Health Commission of Canada [MHCC], 2016). Mental health issues (e.g., bipolar disorder, anxiety, and schizophrenia) can cause personal discomfort and/or difficulties with maintaining social relationships, employment, and independent living (MHCC, 2016a). Services that assist people with mental health issues may perform clinical assessments (e.g., needs assessment, suicide assessment) to better understand their needs and determine which types of services and supports may be useful (Davis, 2013). To assist people with mental health issues, assessments may be performed for a variety of purposes, such as assessing their ability to take care of themselves, the range and severity of their ‘symptoms’, their connections to their family and/or other support networks, or their risk of self-harming or attempting suicide (Davis, 2013).

### *Understanding Assessment and Assessment Tools*

It is important to recognize that in this research I am focusing on the content of contemporary assessment *tools*, which – as I discuss below – are only one component of assessments in their entirety. In this thesis, I understand an *assessment* to be a healthcare worker’s examination of a client’s/patient’s concerns and/or ‘symptoms’, the biopsychosocial factors that may be relevant to their issues, and potential solutions for such (Probst, 2015). An assessment *tool* is “a specific procedure for deriving measures of the aspects of a person, event, environment, or functional relations among variables” (Haynes, Smith, & Hunsley, 2018, p. 9). That is, to understand who clients/patients are

and what their situation is, assessment tools provide a structured outline of factors that may be investigated, as well as guidelines for how such factors should be recorded and/or measured (Probst, 2015).

Assessment is a continuous process with many phases within which a variety of tools may be used to record and potentially scale clients'/patients' information (Davis, 2013). As clients'/patients' 'symptoms' and biopsychosocial issues may change over time and/or context, healthcare workers may need to complete additional assessments to collect updated information which may inform their current understanding of clients'/patients' issues and needs (Probst, 2015). While some healthcare workers may be mandated to use certain assessment tools (Champlain Pathways to Better Care [CPBC], 2017), others may be able to select which tools they use, as well as which parts of the tool they spend more time on, depending on what they understand to be the needs of clients'/patients' they are working with (Lacasse & Gambrill, 2015). With consideration for clients'/patients' needs, healthcare workers may select assessment tools which range in their capabilities (e.g., tools may focus briefly on one specific issue, or extensively focus on a multitude of issues) (Probst, 2015). Furthermore, an assessment may incorporate a variety of tools used by a team of different types of healthcare practitioners (Cagle, Osteen, Sacco, & Frey, 2017). That is, a client's/patient's assessment may not be completed and considered individually, but in consolidation with other assessments that other healthcare practitioners have performed (Cagle et al., 2017). I found this to be the case during my placement at St. Joseph's Healthcare Hamilton West 5<sup>th</sup> Campus [SJHHWFC] – a hospital which specializes in mental health care. At

SJHHWFC, I noticed that clients' medical charts often contained a multitude of different assessments completed on different days by different healthcare professionals. As their charts showed, each of the clients were being assessed by healthcare professionals such as psychiatrists, social workers, occupational therapists, nurses, and psychologists. I felt that the compilation of these assessments reflected a highly comprehensive understanding of clients' physical and mental health, symptoms, treatment, relationships, housing, past experiences, and hopes for the future – i.e., a biopsychosocial understanding which informed their care.

### ***Social Work and Psychosocial Assessment***

In this thesis, I will be discussing issues related to the lack of psychosocial content in commonly used assessment tools. I want to make it clear that in this thesis I am *not* implying that clients'/patients' psychosocial issues are insufficiently engaged with by healthcare practitioners. Both the research literature and my educational and professional experiences have shown me that psychosocial issues are indeed engaged with in the assessment process, especially by social workers. When clients/patients access healthcare, psychosocial assessment by a social worker is one of the first steps taken to ensure their treatment plan is decided with consideration for issues beyond those directly related to biology (Cagle et al., 2017). Social workers' psychosocial assessments ensure that healthcare practitioners are considering patients' mental health issues in relation to their environment (i.e., what is happening around them and to them) (Burns, Dannecker, & Austin, 2019; Corcoran & Walsh, 2016). Such was my experience at SJHHWFC, where I worked alongside social workers who actively worked with

clients/patients to understand them beyond their medically diagnosed illness, by investigating their housing, finances, family relationships, employment, and considering how these factors impacted their mental health. During daily meetings, I was privileged to watch how social workers presented this information to each client's/patient's healthcare team (often composed of psychiatrists, nurses, psychologists, and other social workers), and how the healthcare team would then integrate this information with their own to develop updated treatment plans. With consideration for this experience, it is comprehensible to me that social workers' psychosocial assessments are associated with improved teamwork amongst those involved in the respective clients'/patients' care (Cagle et al., 2017).

### ***Traditional Orientation of Assessment Tools***

Traditionally, assessment tools have been focused on examining people's problems and deficits (Wand, Buchanan, Derrick, & Harris, 2020). Furthermore, assessment tools are often oriented around the biomedical model, meaning they assess people based on the idea that their mental health issues are a 'disease' in need of a 'cure' (United Nations Human Rights Council [UNHRC], 2017; Cazorla Palomo & Parra Ramajo, 2017; Deacon, 2013). The biomedical orientation of assessment tools can be problematic, as people may not be comprehensively assessed with consideration for psychosocial factors that can impact their mental health (Deacon, 2013). Likewise, an assessment exclusively engaging with people's problems and deficits can be problematic, as consideration for people's strengths and values can be essential in improving their mental health (Wand et al., 2020; UNHRC, 2017). Overall, the research literature I

examined suggests that assessment tools are primarily biomedical and problem/deficit oriented. The literature further suggests that the inclusion of strengths/values and psychosocial factors in assessment tools may be necessary to more comprehensively assess people with mental health issues.

### ***My Experience using Assessment Tools***

In my limited experience during my B.S.W placement, I used a variety of assessment tools to work with people with mental health issues in inpatient, outpatient, emergency, and community settings. I noticed that the assessment tools were often limited to a narrow range of topics and found that clients/patients often wanted to discuss content that was not within the scope of the assessment tools I was using. I found that some tools focused more on clients'/patients' problems, while others focused more on their strengths and values. Furthermore, I noticed that clients'/patients' often felt frustrated by having to repeatedly discuss their problems, while in contrast, they appreciated taking time to reflect on things they were able to do and things that they cared about. Compared to the timeframe within which I was to complete assessments, I noticed that I often needed more time, especially when assessments engaged with a larger scope of clients'/patients' issues. Between all the assessment tools I was using, I felt that I was engaging with clients'/patients' strengths/values, problems/deficits, and biomedical/psychosocial factors in pieces. As I recorded assessments into clients'/patients' online medical charts, I understood that each separate assessment was meant to contribute to a more comprehensive understanding of each individual. However, I wondered why so many separate assessment tools were necessary to achieve

this. As a result, I wondered if service providers felt that the assessment tools they were using were ideal in their current form, or if they should change the extent to which they engage with certain issues. I found there was limited literature regarding healthcare workers' opinions on the assessment tools they use to assist people with mental health issues. Hence, I decided to conduct my own research by reaching out to healthcare workers at St. Joseph's Healthcare Hamilton.

In this thesis, I aim to address the following research questions:

1. Do healthcare workers feel like they have enough time to complete assessment tools with the clients/patients they assist?
2. Do healthcare workers think that the assessment tools they use should change the extent to which they engage with clients'/patients' strengths/values and problems/deficits?
3. Do healthcare workers think that the assessment tools they use should change the extent to which they engage with biomedical and psychosocial issues?

### *Overview of Thesis*

In this thesis, I will begin by reviewing some of the research literature on problem/deficit, strength/values, biomedical, and psychosocial models, and their relation to assessment tools. I will also review literature regarding societal oppression and the correlation between mental health issues and several biopsychosocial factors. Following this, I will discuss the humanistic and systemic theoretical frames from which I have

conducted this research. I will then explain the design and methods I used to collect data from healthcare workers, followed by my findings based on my analysis of this data. Finally, I will discuss the implications of these findings and conclude with the limitations of this study and areas for further research.

## **CHAPTER 2: LITERATURE REVIEW**

The purpose of this literature review is to outline some of the documented issues with assessment tools used by healthcare workers to assess people with mental health issues. This chapter will first review current practice and some apparent causes of assessment tool problems, using research literature which outlines how assessment tools can be diminished due to a predominant focus on problems and deficits. Additionally, drawing on existing literature I will describe how strengths focused approaches can potentially improve the aforementioned issues. Next, I will explain the significance of societal oppression and the biomedical and psychosocial models in their influence over mental health assessment tools. Finally, I will discuss the significance of a selection of biopsychosocial issues and their correlation to mental health symptoms as well as mental health assessment.

### ***Deficit Focused and Strength Focused Models***

Traditional mental health assessment tools have been problem oriented - that is - they look for peoples' deficits and potential to come to further harm (Wand et al., 2020). These tools are structured this way despite the present understanding that mental health issues are significantly impacted by social factors that result in "human experiences of



trauma and adversity” (Wand et al., 2020, p. 172). As many assessment tools have historically focused on peoples’ deficits, they have not considered these social factors, nor have they given people opportunities to consider the power they have to improve their mental health (Tondora et al., 2014). This contrasts with the modern understanding that empowering people to take control of their lives can be a necessary part of mental health treatment (Wand et al., 2020; United Nations Human Rights Council [UNHRC], 2017).

It is important to consider the history of clinical mental health treatment as well as the ways in which people with mental health issues have been treated by society (Wand et al., 2020). This is because, historically, many people with mental health issues have been oppressed in both social and medical settings - and the resulting trauma from these experiences continues to impact people today (Wand et al., 2020; UNHRC, 2017). Many assessment tools are structured around the biomedical model, which regards mental health issues primarily as a disease that results in deficits or deviations from what is considered ‘normal’, and therefore should be cured (UNHRC, 2017; Cazorla Palomo & Parra Ramajo, 2017). To balance the historically deficit-focused assessments, modern assessment tools should engage with peoples’ “attributes, assets, abilities, resources, coping skills, past successes, goals, and future hopes” (Wand et al., 2020, p. 172). After examining mental health assessment tools used in Australia and New Zealand in 2020, Wand and colleagues found that the tools continued to primarily engage with peoples’ deficits and their potential to come to harm or harm others (2020). A study in the Champlain region of Ontario, Canada also found that many widely used assessment tools

are deficit oriented despite the call for more tools oriented around strengths and values (CPBC, 2017).

In contrast to problem-oriented assessment processes, which look at people's deficits (Wand et al., 2020), strengths focused assessment processes look at people's skills and capability to recover from their mental health issues (Tse et al., 2016). Strengths focused assessment processes recognize that people with mental health issues hold valuable knowledge about their symptoms and experiences, thereby validating that they hold power in defining their issues and guiding their recovery (Tondora et al., 2014). In their investigation into the alignment of traditional assessment tools with contemporary practice, Wand and colleagues found that "assessment formats did not adequately voice the individual's perspective or promote a truly comprehensive assessment through an exploration of individual strengths, skills and abilities, past successes, and future hopes" (2020, p. 1). Strengths focused assessment processes consider clients'/patients' abilities and past successes as a means to establish their care around skills and experiences that are proven to work well for them (Tondora et al., 2014).

### ***Biomedical and Psychosocial Models***

The mental health field continues to be heavily influenced by the biomedical model, which neglects social aspects of mental health issues in favour of closely adhering to mainstream psychiatry and the practice of recognizing mental health issues primarily as diseases and recognizing the primary 'cure' to be medical intervention (UNHRC,

2017; Double, 2019; Lake, 2019; Deacon, 2013). Overreliance on the biomedical model can result in the prioritization of clients'/patients' presenting symptoms without sufficient consideration for their general wellbeing (Lake, 2019). The biomedical model has maintained significant influence over healthcare because of its impactful emergence during the early 1900's when the cause of physical illness was found to be related to bacteria and treatable with antibiotic medicine (Deacon, 2013). The discovery that biological factors contribute to disease led the healthcare system to classify mental health issues as biological diseases, thus prompting mental health issues to be treated with medicine and physical treatment such as electroconvulsive therapy (Deacon, 2013). Regarding treatment for mental health, the biomedical model continued to thrive throughout the 20th century because of its connection to the pharmaceutical industry, which provided massive funding for medical research while pulling back funding for promising psychosocial treatments (Deacon, 2013). Overall, the biomedical model can be recognized as downplaying psychosocial impacts on mental health (Deacon, 2013).

In contrast to the biomedical model, the psychosocial model recognizes the importance of considering the influence of psychological and social factors on causing and aggravating mental health issues (UNHRC, 2017). The unification of these two models is seen clearly in the biopsychosocial model, which takes "account of cultural, social and psychological considerations as well as biological factors" (Double, 2019, p. 61). According to the UNHRC, mental health policy's embracement of both biomedical and psychosocial models may allow service providers to assess service users more holistically with the inclusion of biological, psychological, and social components of a

person's experience (2017). McQuaid and colleagues understand assessment tools to have been improved because of their increased consideration for biological and social factors in addition to the psychological factors that many traditional tools primarily focus on (2012).

I will now discuss societal oppression and prejudice to establish a social context for the subsequent discussion on several biopsychosocial issues and their impacts on mental health. These biopsychosocial issues were chosen based on existing literature indicating that consideration for such issues is necessary when assessing and/or treating people with mental health issues (Cohen et al., 2019; Hirdes et al., 2020; McQuaid et al., 2012; MHCC, 2012; Portman-Thompson, 2020; Wand et al., 2020).

### ***Societal Prejudice and Oppression***

It is important to recognize psychosocial issues not only in the context of the individual, but also in the broader society from which such issues may be caused and maintained. 'Ism' may be added to the end of a word to associate it with a way of thinking or acting that, in privileging a particular way of being (e.g., straight, white), denigrates and marginalizes other groups of people (Dumbrill & Yee, 2019). When people's thoughts or actions are based on prejudice, the result is oppressive 'ism's' like sanism, racism, sexism, and ableism (Dumbrill & Yee, 2019). In this section I will discuss societal prejudice and related 'isms' to provide a societal perspective to the following psychosocial issues: mental health, gender identity, sexuality, and racial identity.

As mental health issues and ‘mental illness’ are an overarching topic of this thesis, I will first discuss sanism, which is the prejudice and oppression of anyone identified as having a ‘mental illness’ (Dumbrill & Yee, 2019a). Behind sanism lies the idea that people must have a ‘mental illness’ if they think and behave differently from normative societal standards (Dumbrill & Yee, 2019a). As a result of the privileging of a particular normative set of behaviours, prejudice towards those deemed different, labelled ‘mentally ill’, and identified as erratic and dangerous, may be shunned by society or coerced to submit to treatment for their ‘illness’ (Dumbrill & Yee, 2019a). Historically, people with mental health issues have been unwillingly and sometimes indefinitely admitted to hospitals, also called insane asylums or even ‘loonie bins’ (Karp & Sisson, 2010). While under the ‘care’ of these institutions, patients admitted for mental health issues have often been administered anti-psychotic and sedative medication, despite their clear objection (Karp & Sisson, 2010a). In addition to medication, invasive medical procedures such as lobotomies and electroconvulsive therapy have been forced upon patients with mental health issues (Farber, 2012; Curtis et al., 2000). In a society where every person is supposed to have freedom of speech and freedom to choose medical treatment, people with mental health issues have had their voices dismissed - they have been strapped to beds, forcefully administered ‘medical treatment’, and punished for resisting (Curtis et al., 2000). Overall, when considering many of the psychosocial issues discussed in this thesis, it is important to recognize that these psychosocial issues are occurring within the very same society that established sanism and the persecution that accompanies it. Furthermore, it is important to recognize that sanism is not a relic of the

past, as people with mental health issues continue to be stigmatized by societies internationally, i.e., people all around the world are belittled, segregated, and mistreated solely because they are identified as ‘mentally ill’ (Dilkov, Dimitrova, Marinova, & Ulchar, 2020).

Sexism is the oppression of women based on the prejudicial belief that they are unequal to men (Dumbrill & Yee, 2019b). This belief is based around patriarchy – how men have historically and contemporarily held more power and influence than women (Dumbrill & Yee, 2019b). The continued objective of the patriarchy is to ensure that women’s power and freedom are ultimately under the control of men (Miller, 2017). An excellent example of the intersection of sexism and sanism can be seen in the example that while, historically, a person experiencing mental health issues could easily be involuntarily admitted to a psychiatric facility by a physician, married women could also be involuntarily admitted by their husbands (Morrison, 2005). That is, the label of ‘mentally ill’ would make one vulnerable to forced medical treatment and possibly incarceration by a doctor’s judgement, while being ‘mentally ill’ *and* a woman could also make one similarly vulnerable so long as a man – the doctor and/or the husband – judged it to be best. As in the past, women continue to be more frequently labelled and/or diagnosed with ‘mental illness’ compared to men (Tseris, 2019). Regardless of evidence that diagnosing practices lack consideration for the impact of gender related issues on women’s mental health, women’s biology and psychology are often blamed for their overrepresentation in mental health diagnoses (Tseris, 2019). Sexism has also been integrated with prejudice towards people who use substances. Feminist literature reveals

that, more so than men, women have been historically perceived as users of illegal substances and consequent practitioners of sex work (Campbell & Ettore, 2011). As a result, women who use substances have been perceived as ‘out of control’, further feeding the sexist belief that women need to be taken charge of (Campbell & Ettore, 2011).

Dumbrill & Yee explain that “ableism is a form of oppression directed toward disabled people” which holds them back by labelling them as ‘different’ from the privileged societal norm (2019a, p.153). Similar to the ‘mentally ill’ label, people given the ‘disabled’ label have been persecuted by society and deemed a burden to family members and society as a whole. Nario-Redmond (2020) explains how, in the past, and still in various parts of the world, disabled people have been sterilized by force as a means to ensure they do not reproduce, or killed to remove them from society entirely. The author goes on to say that many have been forcefully institutionalized if they were deemed incapable of keeping themselves safe, and sometimes involuntarily used for medical experimentation in these institutions. Overall, many people identified with disabilities have been abused and involuntarily ‘cared for’ and ‘supported’ because of society’s paternalistic view that they cannot care for themselves, that they are powerless and in need of aid (Nario-Redmond, 2020a). As in the past, people identified as ‘disabled’ continue to be treated with prejudice by societal and institutional systems, e.g., being expelled from school for being diagnosed with a disability (Nario-Redmond, 2020b). In resistance to society oppressing and ignoring them, ‘disabled’ people launched the Disabled People’s Movement, which was characterized by the phrase

“nothing about us without us”, meaning that people with the ‘disabled’ label demand that society stop making and enforcing decisions about them without consulting them and gaining their consent (Dumbrill & Yee, 2019a, p.156).

Racism is the prejudice that certain races can be correlated with negative attributes, indicating that certain races are inferior to others (Doob, 2021). For example, anti-black racism originates from the idea that black people were inferior to white people because their land was conquered and colonized, and they were enslaved (Dumbrill & Yee, 2019b). Racism is not limited to ideology that races are inferior, rather, racism is acted on - it is integrated into society through legislation, policies, practices and values - causing racialized individuals to experience visible, invisible, blatant and insidious disadvantages in many aspects of their daily life (Dumbrill & Yee, 2019b). Racism can also intersect with sanism. For example, African American slaves were medically diagnosed and treated for “drapetomania”, a contrived mental illness, when they were perceived to have medicalized ‘symptoms’ such as unwillingness to work and/or tendencies to run away from their ‘owners’ (Matsukawa, 2016, p. 31).

Ryan (2003) defines heterosexism as the belief that homosexuality is unnatural and inferior to heterosexuality. Furthermore, heterosexism upholds the idea that homosexuality is a form of mental illness and an ‘abnormal’ and problematic behaviour (Ryan, 2003). On a societal scale, heterosexism has maintained the general alienation and rejection of anyone identified as queer (e.g., gay, lesbian) (Ryan, 2003). Beyond alienation, ‘homosexuality’ was - by law - a punishable crime in Canada prior to 1973 (Dumbrill & Yee, 2019b). Despite such progress, people who do not identify as



heterosexual continue to be discriminated against within social, institutional, and societal systems, e.g., disowned by family, attacked and neglected at school, constrained to hide and repress their sexuality by societal pressure (DiPlacido & Fallahi, 2020).

Heterosexism can also intersect with sexism and racism, e.g., white male sexual minorities may face less stigmatization compared to people of colour who do *not* identify as men (DiPlacido & Fallahi, 2020).

As sanism, sexism, ableism, racism, and heterosexism have occurred in our history, they have carried on through generations – and continue to do so, e.g., racial minorities may want their children to pass as ‘white’ (Grand, 2020), parents may be pressured to abort a fetus believed to be ‘disabled’ (Nario-Redmond, 2020). Persecution based on mental health, gender, sexuality, ability, and/or race continues to occur on a societal scale and can be intersectional, i.e., people identifying with two or more of these categories may be vulnerable to experiencing two or more types of prejudice, thereby impacting them in a different and potentially more severe way (Dumbrill & Yee, 2019b). Furthermore, this population may also have difficulties accessing support for the issues they face, e.g., barriers to housing due to mental ‘illness’ stigma (Munn-Rivard, 2014), or barriers to healthcare for transgender people due to a lack of services attuned to their needs (Dickey, 2020). Overall, heterosexism and the other ‘ism’s’ discussed in this chapter seem to share an overarching ideology and goal. That is, people deemed ‘abnormal’ and ‘inferior’ to the dominant majority - whether it regards their perceived sanity, ability, gender, race, or sexuality - are understood to be diseased, burdensome, and unworthy of equal rights. Going forward, it is important to consider that the following

biopsychosocial issues that happen to individuals derive from this historical and contemporary societal oppression.

### ***Biopsychosocial Factors and their Relation to Mental Health***

#### ***Social Support***

Social support such as family, friends, and other close relationships can have a significant impact on both the prevention and reduction of symptoms of mental illness (Leach, 2014). Friends and family can help one recover from mental health symptoms by encouraging healthy behaviors and being available to discuss health issues (Leach, 2014). Social supports are especially significant in their capacity to reduce isolation and loneliness, which are known to be a risk factor for deteriorating mental health (Leach, 2014). Words of comfort and support, and close personal conversations that feature care and empathy can assist in emotional stability and the sustainment of healthy self-esteem (Leach, 2014). Emotional dysregulation and negative self-image are known to worsen symptoms of mental illness; therefore, words of support can ultimately prevent mental health deterioration (Leach, 2014). Family and friends can also be a source of material assistance such as healthy food or housing, which helps people avoid the negative impacts that poverty can have on their mental illness (Leach, 2014). Just as family and friends are in positions to assist with one's mental illness, their closeness may instead result in worsening mental health symptoms. Families that show cold criticism and disdain for their family member's mental illness are likely to worsen these mental health symptoms, potentially to the extent of reversing any improvements from recovery

(Leach, 2014). Family and friends that respond to people's mental health issues without empathy or sincere consideration can leave them feeling disappointed in the attempted assistance (Leach, 2014). Family and friends may recognize that they were unhelpful and become disappointed in themselves or become frustrated that the person they tried to help did not respond positively to their attempt; either way, such results can negatively impact their relationship (Leach, 2014).

### ***Employment***

Amongst the population of people with mental health issues, meaningful employment is associated with a reduction in symptoms of mental illness and number of hospitalizations, while unemployment is associated with worsening mental illness (Canadian Mental Health Association Ontario & Centre for Addiction and Mental Health [CMHAO & CAMH], 2010; Gibbons & Salkever, 2019). Additionally, employment is known to improve people's "cognitive abilities, self-esteem, and social networks" (CMHAO & CAMH, 2010, p. 2). For people with mental health issues, employment is also associated with financial wellbeing and greater access to resources that allow for independent living (CMHAO & CAMH, 2010). All these benefits may come to reality when people with mental health issues have access to meaningful and fair-paying employment, however, there are many barriers preventing this population from accessing such employment (CMHAO & CAMH, 2010). The likelihood of people with mental health issues being employed is already lower than that of the general population, and instances of meaningful employment in well-paying jobs are even lower (CMHAO & CAMH, 2010). One reason for this may be that people with mental health issues often

begin experiencing symptoms in adolescence - a time when engagement with institutionalized education is crucial in gaining access to college or university (CMHAO & CAMH, 2010). Without a college or university education, people are more likely to be employed at jobs with lower pay, less security, and fewer benefits (CMHAO & CAMH, 2010). Such jobs are known to be associated with a decline in mental health, which is understandably dangerous for a population that already experiences harmful mental health issues (CMHAO & CAMH, 2010).

### *Housing*

In Canada, people with mental health issues are more susceptible to being homeless or having inadequate housing (Munn-Rivard, 2014). Both homelessness and low-quality housing are known to worsen the mental health of those experiencing them (Munn-Rivard, 2014; Prasad, 2017). People experiencing inadequate housing or homelessness are more likely to abuse substances, self-harm, and complete suicide (Munn-Rivard, 2014; Prasad, 2017). Often, peoples' mental health issues will continually intensify so long as they remain homeless or inadequately housed (Munn-Rivard, 2014). Furthermore, homelessness is also associated with a poor connection to family and other social supports that may result in difficulties obtaining legal documents that are typically essential to accessing many social services and healthcare - which are the very supports that this population critically needs to improve their mental health and housing (Munn-Rivard, 2014; Prasad, 2017). As a result, many people will not be able to access healthcare and will not be diagnosed or provided treatment (Munn-Rivard, 2014). While poor housing conditions aggravate mental health issues, proper housing is

recognized as a significant component of recovery from these issues (Munn-Rivard, 2014). One of the primary barriers to proper housing faced by people with mental health issues is the lack of employment income and financial security (Munn-Rivard, 2014). As mentioned in the previous section on employment, people with mental health issues may face barriers getting educated which may result in employment and financial barriers, which ultimately may lead to barriers to proper housing. In addition to financial issues, people with mental health issues may struggle to find proper housing due to discrimination by property owners who will refuse to rent to them solely based on their identification as having mental illness and the stigma attached to it (Munn-Rivard, 2014).

### ***Financial Wellbeing***

The effects of poverty can be especially harmful towards people who are also experiencing mental illness (Forchuk et al., 2017). A study in London, Ontario shows that many people who experience poverty alongside mental health issues have similar experiences with poverty (Forchuk et al., 2017). Common experiences related to poverty often revolve around housing, employment, stigma, substance use, and the use of supportive services (Forchuk et al., 2017). As a result of stigmatization, many people with mental health issues struggle to find living-wage work that will be accepting and accommodating towards their health issues (Forchuk et al., 2017). Furthermore, those living on government assistance such as Ontario Works typically face additional barriers in finding work because changes to their financial situations may disqualify them from these supports - which include health and dental care not covered by the Ontario Health Insurance Plan (Forchuk et al., 2017). That is, employment has the potential to make

some essential healthcare services inaccessible to people in poverty. As a result of such employment challenges, this population struggles to find quality housing and may end up in low-income housing where they report that many tenants use substances (Forchuk et al., 2017). Living amongst people who use substances can make it difficult for people to avoid using substances themselves, especially if they have experienced substance use issues in the past (Forchuk et al., 2017). As a result of their poor living conditions and other financial challenges, people with mental health issues may become too mentally strained to seek out and connect with supportive services that may be able to assist with their financial and/or mental health issues (Forchuk et al., 2017).

### *Substance Use*

When people simultaneously have issues with both substance use and mental illness, it is called a concurrent disorder. People with concurrent disorders often struggle to find suitable support because there is a lack of care facilities that engage with both substance use and mental health issues (Canadian Mental Health Association & Addictions & Mental Health Ontario [CMHA & AMHO], 2013). The lack of effective services for treating people with concurrent disorders often causes them to end up using emergency services because their issues go unaddressed until they result in crises (CMHA & AMHO, 2013; Schuetz et al., 2013). As a result, service users with concurrent disorders more often require emergency service and hospital use compared to users with mental health or substance use issues separately (Hakobyan et al., 2020). The homeless population is composed of a significant number of people who have concurrent disorders (Schuetz et al., 2013). Furthermore, many people in this population who are

not homeless live in poor quality housing (Schuetz et al., 2013). People with concurrent disorders often have physical health issues and a significantly lower than average life-expectancy (Schuetz et al., 2013). One study analysed people with concurrent disorders in residential treatment and showed that they experienced more severe psychopathological distress than psychiatric inpatients (Schuetz et al., 2013). This implies that - compared to people with severe mental illness - mental suffering may be more intense amongst people who also have substance use issues. For people with concurrent disorders, it may be more effective to seek them out and engage them as opposed to waiting for them to seek treatment (McKee, 2017).

### *Trauma*

Trauma is caused by direct or indirect exposure to physical and/or sexual harm, and/or experiences involving death (Portman-Thompson, 2020). Traumatic experiences can result in Post-Traumatic Stress Disorder (PTSD) (Portman-Thompson, 2020). Both traumatic experiences and PTSD are known to increase the likeliness that someone with a serious mental illness will experience more extreme mental health symptoms (Mauritz, Goossens, Draijer, & van Achterberg, 2013). When Mauritz and colleagues reviewed 33 studies about mental illnesses such as major depression and schizophrenia, they found that every single study explained that exposure to trauma was extremely common amongst people with mental illnesses (2013). In addition to increased symptom severity, people with serious mental illness are less likely to have positive health outcomes and more likely to attempt suicide if they also have been identified with PTSD (Mauritz et al., 2013; Portman-Thompson, 2020). Despite the correlation between trauma and mental

illness, symptoms of trauma are often unnoticed by mental health service providers because they can be extremely similar to symptoms of mental illness (Mauritz et al., 2013). Furthermore, mental health service providers may avoid asking clients/patients about traumatic experiences out of concern that a client/patient may become anguished from the memory - resulting in a worsened mental state (Mauritz et al., 2013). However, evidence to support this concern is unfounded (Mauritz et al., 2013). Overall, there seems to be a necessity for the inclusion of trauma assessment when assisting people with mental health issues because their trauma is 1) often overlooked by service providers, and 2) closely integrated with symptoms of their mental illness (Mauritz et al., 2013; Portman-Thompson, 2020). It is not enough for service providers to only assess symptoms of illness when there may also be opportunities to understand experiences of trauma and their connections to patients' symptoms throughout their lives (Portman-Thompson, 2020). Additionally, showing an interest in clients'/patients' lived traumatic experiences may assist service providers in building an effective working relationship with them because it shows care and willingness to establish a human connection (Portman-Thompson, 2020).

### *Suicide*

The fact that people with mental illnesses are overrepresented in deaths by suicide shows that there is a significant correlation between mental illness and suicide (Schmutte, Costa, Hammer, & Davidson, 2021; Davis, 2013). In their study of 174, 001 people who died by suicide, Schmutte and colleagues found that approximately 41.7% of them had some form of known mental illness (2021). It is important to consider that the remainder



of suicides may have also included people with unknown mental health issues, therefore it is likely that more than 41.7% of the studied suicides were amongst those with mental illnesses. Of the 41.7%, 8.7% had a severe mental illness such as depression or schizophrenia (Schmutte et al., 2021). Amongst those with severe mental illness, there is a visible increase in likeliness of suicide close to the time they stop taking their prescribed medication, and/or are discharged from a psychiatric facility (Schmutte et al., 2021). In contrast, consistent use of antipsychotic medication is associated with a decreased risk of death by suicide amongst people with mental illnesses (Schmutte et al., 2021; Malhi, Bell, & Mannie, 2021). Of the 174, 001 studied suicides, Schmutte and colleagues found that 77.4% were amongst males, indicating that there are factors attributed to gender which can significantly increase the likeliness of suicide (2021).

### ***Self-Harm***

Mental disorders are commonly present in people who practice self-injury – a study by Beckman and colleagues found that 48.3% of men and 49.5% of women admitted to hospital for self-harm also had a mental disorder (2016). A history of self-harm during childhood and adolescence can be indicative that someone is more likely to also experience mental illness, substance use, and/or suicide attempts during the initial period of self-harm and later in life (Beckman et al., 2016; O'Hare, Shen, & Sherrer, 2017). Approximately 75% of severe self-injury resulting in significant damage to one's body is completed by people experiencing a psychotic episode because of a mental disorder (Houston, 2017). This is similar to data from Canadian hospitals in 2010, which showed that mental illness was associated with approximately 70% of patients

hospitalized for self-harming (Davies, 2013). People may self-harm for many reasons such as: to feel in control, to self-punish, to relieve anxiety or depression (Houston, 2017). Therefore, investigation into people's motives for self-harming can lead to valuable information about their problems and desires. Sometimes self-harm is used to prompt the brain to release dopamine, and for this reason, self-harm may be understood as a substance addiction (Houston, 2017). Similar to substance use withdrawal, people may experience withdrawal symptoms when they stop self-harming because their brains stop releasing the large bursts of dopamine they adapted to (Houston, 2017). Suicide attempts and completion are significantly more common amongst people who frequently self-harm, and this may be in part due to relationships between self-harm and suicide preparation (Houston, 2017). Frequent self-harm can make a person dull to pain, resulting in a desire for more severe self-harm to increase the pain to a level they can feel (Houston, 2017). Such severe self-harm (e.g., deep cutting) is often physically similar or identical to a suicide attempt, meaning that someone who practices severe self-harm will be more familiar with the process of completing suicide (Houston, 2017).

### *Gender*

Compared to the general population, people who identify as gender minorities such as transgender or gender nonbinary are more likely to have been identified with issues with mental illness, substance use, self-harm, and suicide (Dickey, 2020; Kuper, Bismar, & Ryan, 2020). A study in Canada showed that people identifying as transgender are 50% more likely to binge drink compared to the general population (Kuper et al., 2020). Amongst the transgender population, symptoms of mental illness

can be more difficult to identify because they can share similarities with personal issues related to gender (Dickey, 2020). In addition to frequent mental health issues and substance use, it is common for gender minorities to have experienced physical and/or sexual trauma (Dickey, 2020). In situations where transgender individuals require healthcare or housing, they are more likely to encounter barriers to service because of their gender (Dickey, 2020). For example, a transgender person may have a more limited selection of supportive housing, such as housing for women escaping domestic abuse, because organizations may have strict rules about tenants' sex at birth. Gender-based harassment is a common experience for the transgender community, and such experiences can induce feelings of worthlessness and mental health issues such as anxiety, and can be a driving factor towards suicide (Kuper et al., 2020). The harassment of members of the transgender community is not only commonly perpetrated by the public, but by the police as well (Kuper et al., 2020). Transgender communities report that when they seek professional help, they are sometimes doubted or advised not to transition (Kuper et al., 2020). Between police harassment and dismissal by health professionals, it seems logical to expect members of this community to have distrustful relationships with organizations designed to help the public. In addition to the transphobic harassment they experience in public, transgender people can internalize transphobia and persecute themselves with thoughts of self-hatred based on their own gender (Kuper et al., 2020). Social circles such as friends and family can have a significant impact on the mental health of people identifying as transgender (e.g., their

mental health issues can worsen if family and friends are unaccepting and abusive, while such issues can improve with supportive and loving social circles) (Kuper et al., 2020).

One does not need to be a gender minority to have their gender negatively impact their mental health. Both biological men and women experience negative effects on their mental health based on their gender. Men and women experience mental health issues, and are often victims of physical violence perpetrated by other men, however, unlike women they rarely go to anyone for support because of the social construct that men should be tough and self-sufficient (World Health Organization [WHO], 2005). As a result, men's traumatic experiences and mental health symptoms often go ignored, leaving them to worsen over time. Compared to being a man, being a woman has arguably more negative impacts on mental health. Our societal structure holds higher regard for men, and grants greater power to men, and as a result, women are made vulnerable to feeling helpless and inferior - potentially resulting in negative effects to their mental health (Williams & Watson, 2016; WHO, 2005). Women are more likely to experience depression than men, while men are more likely to have substance use disorders (WHO, 2005). Women are more often put in positions where they are the sole provider for their children, and such situations often result in poverty and overwork which can cause significant harm to their mental health (Who, 2005; Mental Health Commission of Canada [MHCC], 2012). Overall, women continue to be controlled and oppressed by patriarchal prejudice that they are 'mentally ill', 'out of control', and less capable than men (Tseris, 2019; Miller, 2017; Campbell & Ettore, 2011).

### *Sexuality*

Compared to heterosexual people, those identifying as LGBTQ2S+ (Lesbian, Gay, Bisexual, Transgender, Queer, plus) more frequently experience mental health issues and thoughts of suicide (DiPlacido & Fallahi, 2020). DiPlacido and Fallahi (2020) go on to say that, oftentimes, mental health issues amongst the LGBTQ2S+ population can be linked to society's suppression and oppression of all sexualities aside from heterosexuality; that in addition to the suppression of LGBTQ2S+ communities on a societal scale, LGBTQ2S+ individuals often experience abuse and alienation directly in their personal lives. During childhood, people identifying as LGBTQ2S+ more often experience physical and sexual abuse at home and at school. The authors note that society's demonization of non-heterosexuality can cause LGBTQ2S+ individuals to internalize hatred for their own sexuality, potentially causing harm to their mental health. Unlike LGTQ, people identifying as bisexual may face the unique challenge of biphobia, where they may be discriminated against by both LGTQ *and* heterosexual people (DiPlacido & Fallahi, 2020). In this situation, it is thought that some LGTQ individuals may hold prejudice because bisexuality can look like heterosexuality, while some heterosexual individuals may hold prejudice because 'homosexuality' is socially demonized (DiPlacido & Fallahi, 2020; Galupo, 2020). Amongst LGBTQ2S+ individuals, bisexual people are most likely to experience issues with mental illness, substance use, suicidal ideation, and attempted suicide (Bostwick & Harrison, 2020). LGBTQ2S+ individuals - especially bisexuals - report a greater frequency of experiencing sexual and physical assault, of which such trauma may imply a greater likeliness of developing post-traumatic stress disorder (Bostwick & Harrison, 2020).

### ***Racial Identity***

Different racial identities can be associated with unique complications regarding mental health issues and mental health care. Furthermore, racism can negatively impact healthcare received by racialized groups, e.g., people of colour being communicated with less, more often dismissed, and thought of as biologically different compared to white people (Moreland-Capua, 2021). Compared to other racial identities, European Americans are reported to be more likely to have substance use disorders, which increases the likelihood that they will present with concurrent disorders because severe mental illness is more common amongst people who use substances (Chang & Downey, 2012). Asian Americans may avoid seeking help with mental health issues because they have cultural beliefs that such issues should only be kept between a person and their family (Chang & Downey, 2012). As a result of avoiding professional help, they may present with more severe mental health symptoms that worsened during the time they were not addressed properly (Chang & Downey, 2012). A study of African Americans with Major Depression found that they were more likely to fear professional mental health treatment (U.S. Department of Health and Human Services [HHS], 2001). Furthermore, compared to white people, African Americans were more likely to feel like doctors treated them poorly because of their race (HHS, 2001). The hesitance of African Americans and other racial minorities to access mental health services has been attributed to historic and present-day social and systemic persecution they have faced because of their race (HHS, 2001). African Americans were forced into slavery for centuries, Native Americans were forced to leave their homes and live in Government appointed

reservations, and many Japanese Americans were imprisoned for the duration of World War II (HHS, 2001). After surviving historical systemic injustices, it seems rational that racial minorities would hesitate to seek assistance that is ultimately from the same source of their historic and present-day mistreatment. In response to the many effects that racism and white supremacy have had on people's experiences with mental illness, including intergenerational effects, service providers should recognize the implications of such experiences and alter their practice accordingly. Considering that mental health assessment is often one of the first interactions between workers and clients/patients, it seems crucial that assessments are considerate of these impacts.

### ***Conclusion***

The extensive ways in which these intersecting biological, psychological, and social issues can be interconnected with mental illness and mental health care shows that there may be justification to broaden assessment tools' engagement with issues beyond the scope of medicine. This literature review has provided perspectives on assessment tool deficiencies as well as several factors that can significantly impact mental health. Linking these issues together is the idea that mental health assessment tools could be improved by approaching clients'/patients' mental illness holistically. This would call for assessment tools to engage with many non-medical aspects of clients'/patients' lives that may go neglected by traditional assessment tools which often excessively prioritize symptomatology.

### **CHAPTER 3: THEORETICAL FRAMEWORK**

For my research project, I chose perspectives that would help me to analyse the data with a focus on holism. I drew from both systems and humanistic theoretical frames to investigate assessment tools used by St. Joseph's healthcare professionals to assist people with mental health issues in Ontario, Canada. I chose these theoretical frames because I believe there is a valuable connection between their principles and the methods and goals of the assessment process. In this chapter, I describe these two theoretical frames. I also speak to my research goals and articulate the reasons I believed that these theoretical frames were ideal in guiding me towards achieving them.

The basic theoretical assumptions behind systems theory are the following. Firstly, systems contain parts which are all connected to each other in some way (Langer & Lietz, 2014). As a result of these connections, changes to any part of a system will affect the entire system (Langer & Lietz, 2014). Secondly, "a system is more than the sum of its parts" (Langer & Lietz, 2014, p. 39). That is, the value of individual parts will change when they are established as a system. I find this framework compelling because I am interested in the ways in which individuals are connected to the social and institutional systems in which they exist. When thinking about the issues of individual people, I wanted to be considerate that their issues are also systemic issues, and that they are connected to the workings that occur within larger systems. In my research, I wanted to investigate the extent to which assessment forms, that are used to assist people with mental health issues, are – or are not – inclusive of systemic factors that may be at play in their lives. This goal



stems from my understanding – based on my professional and academic experiences in the mental health field – that many assessment forms tend to focus on diagnosing or assessing clients’ needs based mainly on their presenting symptoms and medical history (Cazorla Palomo & Parra Ramajo, 2017; Double, 2019). This can be problematic because it may result in the oversight of some non-medical factors that cause significant impact to clients’ mental health. I also found this framework compelling because it considers that the idea of being a person changes in a systemic context compared to an individual context (Schirmer & Michailakis, 2019).

This distinction between the person as an individual and the person as a part of a system is relevant to my understanding of the positioning of the healthcare workers that completed the survey used in this research study. In this research, I recognized that their individual opinions are also based on their experiences as ‘people’ in the systemic sense. They are people working in association with other people as parts of a system that result in a greater whole. Therefore, the information they share with me will be based on their own personal thoughts and experiences in relation to the powers and boundaries of the medical system in which they operate.

The basic theoretical assumptions behind humanistic theory are the following. Firstly, all people should be treated with care regardless of their qualities or actions (Langer & Lietz, 2014a). Humanism assumes that all people are worthy of care simply because they have inherent value as human beings (Langer & Lietz, 2014a). Humanistic theory also assumes that it is necessary for people to have this outlook on human value to foster relationships that can elicit positive changes (Langer & Lietz, 2014a). Humanistic theory

thereby implies it is important for healthcare workers to have this outlook on human value to better assist their clients/patients. Finally, humanistic theory assumes that all people are always changing, for better or worse, and that their self-image has a large impact on the types of changes that occur in their lives (Langer & Lietz, 2014a). I found this framework compelling because I believe that unconditional care is an essential part of working with people who have mental health issues. I believe this from listening to stories from clients/patients with mental health issues - stories which share similar themes regarding being misunderstood and uncared for by others. I think it is crucial for mental health workers to challenge such neglect and treat people with mental health issues with the same care and consideration that they would for anyone. My experiences using assessment tools in inpatient, outpatient, emergency, and community settings has helped me recognize that the act of caring does not come 'bundled' with assessment tools, rather, it lies solely with the healthcare worker, and it is their responsibility to ensure it happens. Furthermore, whether they can ensure this happens may depend on the limitations imposed by the healthcare system in which they work.

Both systems theory and humanistic theory informed my data collection and analysis. The systems theoretical frame directed me to include an analytic perspective that would pay attention to connections between systemic factors such as poverty, racism, and unemployment, and the lived experiences of clients/patients with mental health issues. The systems theoretical frame ensured that my survey tool included questions about systemic factors, and that the data was analysed with consideration for these factors which exist outside of the client as an individual. I believe that this perspective is valuable because, as

noted above, I am critical of the lack of consideration for systemic issues within tools used to assess the needs of people with mental health issues. Therefore, I found it necessary to examine healthcare workers' use of these tools from the position that such considerations are essential for assessments to be most effective. The systems theoretical perspective also aided in my consideration that mental health assessments are conducted within medical environments by workers who are trained by academic and professional institutions to fill performance roles in healthcare (Schirmer & Michailakis, 2019b; Thompson, 2018). That is, systems have created 'the healthcare worker' and 'the healthcare environment', so the experiences of clients can also be impacted by these systems. Furthermore, a systems perspective ensured that I was considering that individuals within the same systems may not be affected - or perceive the ways they are affected - in similar ways (Schirmer & Michailakis, 2019a). This helped me pay attention to the fact that the results I received may have come from healthcare workers who shared similar systemic interactions, but this did not guarantee that their experiences would be similar. Therefore, their interactions with assessment tools were also not guaranteed to be similar, even if the same tool was used by the same type of healthcare worker in the same service sector.

In designing my data collection survey tool and analysing my data, the humanistic theoretical frame directed me to include a perspective that paid attention to any connections between the assessment tool structure and participants' perspectives as to the tools' attention to clients' individual characteristics and health. Although I am aware it is debated, I believe that individuals may be impacted by issues exclusively attributed to their biology. Therefore, I felt it necessary to analyze participants' perspectives of assessment

tools with consideration that their clients'/patients' symptoms may *not* be related to psychosocial issues. That is, I believe some clients/patients can have issues which *are* primarily medical, in which case the medical model can be favourable. In the work of Hategan, Saperson, Harms and Waters, I find support for the position that a medical model understanding of mental health issues - which focuses primarily on physical and mental health symptoms - can be compatible with humanism so long as clients are primarily understood and respected as people first by all healthcare staff they encounter (2020).

I found it essential to include the humanistic theoretical frame to ensure that the survey questions were not written in a way that minimizes or simplifies the issues of service users, and instead maintains that their issues are extremely complex and personal. Although this survey focused on the perspectives of health care workers, and did not ask questions about service users, I believe that it was important to construct it as though service users would have access to it. This is to maintain a standard of respect for service users that I hope to incorporate in my future research and practice. As Katz-Sidlow explains, disregarding the dignity and emotional state of service users being treated in medical facilities can worsen their physical and mental health by minimizing their humanity (2002). I recognize that this extends into writings regarding service users, therefore I believe that being considerate of their humanity in my research is necessary in upholding the very principles I am investigating.

Systems theory seems to focus on external factors, while humanistic theory seems to focus on internal factors. Therefore, I felt that the combination of both frames allowed me to perceive how healthcare workers understand whether, to what extent, and which

assessment tools engage with a larger scope of clients' issues. Using systems theory alone would have limited my focus towards external factors such as racism and homelessness without consideration for the ways in which the human as a unique individual is located in such factors. In contrast, exclusively focusing on humanistic theory would have been dismissive of the great influence that systemic factors have on individual issues.

The primary limitations of my theoretical frames were their lack of consideration for more medically inclined perspectives offered by theories within the medical model. The theories I used did not involve consultation with medical literature such as the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (American Psychiatric Association, 2013). Furthermore, these theories are not supported by such literature. Therefore, they only allowed me to examine the opinions of healthcare workers from a systems and humanistic perspective without examining them alongside or from the perspective of more medically inclined theories.

#### **CHAPTER 4: DESIGN AND METHODS**

Many different assessment tools are used by health practitioners to inform diagnosis and decision-making to support people with mental health issues (Champlain Pathways to Better Care, 2017). Drawing on the perspectives of clinical mental health practitioners who use these tools, I hoped to gain insight into which medical and social issues were most and least represented within assessment tools, as well as how much healthcare workers thought that these issues should be included. To answer these

questions, I asked clinical mental health practitioners to answer multiple choice and scaling questions to share their opinions in a format that could be analysed to allow for implications that may inform future research. Hence, this research employed a quantitative survey design to gather exploratory data from a sample of healthcare professionals at St. Joseph's Healthcare Hamilton.

### ***Data Collection***

The primary objective of this Master's level study was to learn, from health practitioners, more about the assessment tools they use to inform their decision-making around treatment and interventions for people with mental health issues. By asking questions as to which tools they use and their opinions as to the tools' usefulness and possible gaps, I hoped to answer the questions: do health care practitioners think that current mental health assessment tools need improvement? If so, how can they be improved? These questions were inspired by practical issues that I had noticed when researching possible deficits in assessment tools that might result in suboptimal care for people with mental health issues (Champlain Pathways to Better Care, 2017; Wand et al., 2020).

Using the software Limesurvey, I created a survey of 27 questions informed by the research literature and my past experiences using assessment tools (See Appendix A). Surveys were sent by email and data collection began on Monday, June 21st, with two additional emails being sent out between July 5th and August 12th to remind potential participants of the survey. The final response was received on August 16th, but the

survey was left open to allow for any more responses. The survey was officially ended on September 13th. The survey was shared via a URL link given exclusively to an employee at St. Joseph's Healthcare Hamilton who had agreed to support recruitment, and subsequently shared exclusively with employees of St. Joseph's. I designed the questions to be scaling, multiple choice, and yes/no questions. Scaling questions were used to record participants' thoughts about the degree to which their assessment tools did or did not engage with a specific subject. Scaling questions were also used to record the degree to which healthcare workers believed such subjects should be included in the assessment tools they use. Multiple choice questions were used to collect information about the participants' job titles, departments, and basic information regarding their most often-utilized assessment tools. Some multiple-choice questions allowed participants the option of selecting an "other" category and typing in an alternative answer. Two questions about the time taken to complete assessments required numbers to be typed as an answer.

### ***Recruitment***

The criteria to be a participant in this study was the following:

- To be employed by St. Joseph's Healthcare Hamilton
- To have a practice that includes the use of assessment tools to directly assist clients/patients who have mental health issues
- To be between the ages of 20-70

Ages 20-70 were chosen as they are the lowest and highest reasonable age limits that apply to any current staff member of St. Joseph's Healthcare Hamilton who would be involved in conducting mental health assessments. There were no exclusion criteria regarding gender or race. To support recruitment, I contacted a social work supervisor at St. Joseph's Healthcare Hamilton and requested for them to distribute my survey to any staff who use assessment tools to assist people with mental health issues, e.g., social workers, occupational therapists, nurses. I requested for my survey to be sent to workers from all three of St. Joseph's Hamilton locations to increase the likelihood that I would reach my desired sample size. Additionally, I felt that including more locations would increase the likelihood that I received responses from participants located in a broader variety of departments, i.e., emergency, inpatient, outpatient, and community services. Surveys were sent and received exclusively by email. Emails contained a link to the survey in addition to a recruitment script (See Appendix E) and letter of information and consent (See Appendix C). Participants had as much time as they needed to respond and had the ability to stop the survey and resume at a later time. Based on the format and number of questions, this survey was estimated to take five minutes to complete. I was aiming for a sample size of seven to ten participants for each of St. Joseph's three campuses for a total of 21-30 participants. This was deemed manageable for a twelve-month MSW program, while still providing sufficient data to draw some implications. The response rate was approximately 6 participants per site for a total of 17 responses.

### *Ethical Considerations*



Sending out a multiple-choice survey via email was the most suitable approach to answering my questions for multiple reasons. First, it gave more flexibility for healthcare workers to dedicate time to complete it and would require less of their time than a qualitative interview (Bruce, Pope, & Stanistreet, 2008). With additional consideration for the in-person limitations caused by the COVID-19 pandemic safety measures, I recognized that healthcare workers would have restrictions as to who they could see in person, as well as potentially stressful and time-consuming alterations to their personal and professional obligations. Therefore, rather than conduct lengthy video interviews where workers may need to alter their schedules and time-manage, I decided to send out a survey that workers could complete in a few minutes whenever they had time to spare.

When creating and distributing the anonymous survey, I had to make a few ethical considerations. Primarily, I was concerned that questions that may suggest assessment tool problems could make healthcare workers feel like they were doing insufficient work. If workers were to express dissatisfaction with the tools they were using, I worried they might subsequently feel stressed by reflecting on how such assessment tool problems are negatively impacting the services they provide to their clients/patients. Typically, I would have been confident that healthcare workers would be unperturbed by taking time to reflect on their work. However, due to COVID-19, I had considered that our healthcare system may become overwhelmed, causing staff to see radically more clients/patients and work longer hours. Therefore, I was concerned that even minor reflection regarding potential work-related problems could cause them stress in an already stressful work environment. Overall, I decided that this risk was negligible

because the survey was completely anonymous and voluntary, with workers being made aware that they were not obligated to complete it and could stop answering questions at any time.

The second ethical consideration I had to make was regarding professional risk on the part of healthcare workers who completed my survey. If individual workers were to be exposed regarding their discontent with the assessment tools they use, they may face criticism from colleagues or reprimand from supervisors, potentially resulting in undue stress and an overall negative impact on their professional careers. To ensure that this could not happen, I structured the survey to not ask for any identifying data, and I arranged for results to be sent to me with only random numbers to identify individuals. Furthermore, I was never given access to the email addresses of anyone my survey was sent to. Thus, there was no existing information indicating which individuals did or did not complete my survey, making the exposure of individual workers within the workplace or public an impossibility. This project received ethical clearance from the Hamilton Research Integrated Ethics Board on June 15th, 2021 (See Appendix B).

### ***Data Analysis***

Before analysing the survey data, I uploaded it from Limesurvey to Google Sheets (a program like Microsoft Excel). I exempted 13 incomplete submissions and only uploaded 17 complete submissions. Surveys were recognized to be “Incomplete” when participants answered and/or reviewed the survey *without* submitting it at the end. Despite some participants not answering some questions, their submissions were

recognized as “Complete” so long as they submitted it as complete, as they were allowed to choose to not answer questions. The absence of some participants’ answers is explicitly indicated in the findings section. I left all scaling answers in their numerical form and tallied multiple choice answers such as those asking participants to select from “increase”, “keep same”, or “decrease” by assigning each answer a value of 1 and adding them to find the sum. For example, ten participants answering “increase” would be translated into “10”, which I would then illustrate in a graph with the label “increase”, such as in *Figure 3* in the findings section.

After receiving completed surveys, I analysed the data first using descriptive statistics to look at the frequency of responses to each question (Cooksey, 2020). I then used this data to generate graphs and tables that allowed me to better recognize contrasts and consistencies between participants’ answers. Informed by critical theory and engagement with the relevant research literature, I further analysed the data as to the alignment between participants’ responses and the research literature.

### ***Limitations to Methods Used***

I chose to gather quantitative data because this form of data could more reasonably be collected from a larger number of health professionals. I felt that quantitative surveys would be accessible to a greater number of participants because they would be easy to circulate by mass email and would not be demanding of much time or commitment. I anticipated that the collection of qualitative data by a method such as interviewing would result in fewer participants due to the impact of COVID-19 on the

healthcare system in Hamilton. I recognized that qualitative data may have been valuable in my research, as I am exploring the opinions of healthcare workers in relation to the assessment tools they use. However, I worried that I would only secure one or two participants, which may have left me with an insufficient amount of data to work with. Despite my use of quantitative surveys, it is likely that the impact of COVID-19 on the healthcare system still decreased the number of healthcare workers who participated. This is likely why the number of responses I received was low for a quantitative study. Overall, the low number of responses limited my ability to compare the data to literature, draw conclusions, and point towards future areas of research.

## **CHAPTER 5: FINDINGS**

This chapter will begin by explaining the variety of participants' roles in healthcare and the different assessment tools that they indicated using to assess people with mental health issues. Following this, the chapter will describe the variety of purposes which participants indicated using assessment tools to achieve. This chapter will then analyse data that reflects participants' beliefs regarding the following subjects:

1. The extent to which the assessment tools they use currently do and should engage with a range of biopsychosocial issues
2. The amount of time they have and the amount of time they think they need to complete assessments

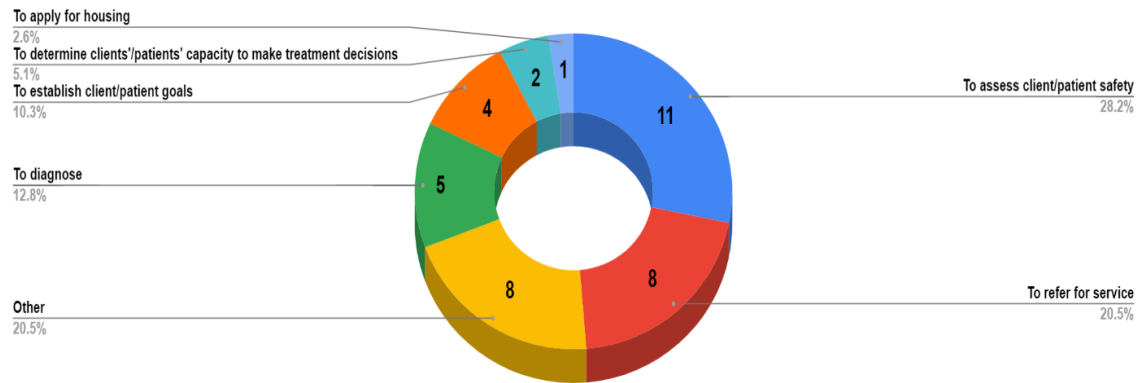
3. The extent to which the assessment tools they use currently do and should engage with clients'/patients' strengths/values and problems/deficits

### ***Participants' Healthcare Roles and used Assessment Tools***

Seventeen participants completed the survey. They included six social workers, five occupational therapists, four nurses, and two psychologists. Six worked in inpatient roles, five in outpatient roles, three in emergency roles, and three in community roles. The assessment tools they used most often were as follows: Beck Depression Inventory (n=2), "Columbia Suicide Scale" (n=5), "McLean" (n=1), "Independent Living Scales" (n=2), "Verbal Reasoning" (n=1), "Mental Status Exam" (n=2), "GAD 7 Scale" (n=2), "PHQ 9" (n=2), PTSD Checklist PCL (n=2), "Mini-Frogs" (n=1), Brief Psychiatric Rating Scale (n=1), "Diagnostic Assessment Research Tool" (n=1), and "TAG" (n=1). Some tools are shown in quotations to indicate that they were typed that way by the participants, rather than being selected from tools listed in the survey. One worker did not identify which assessment tool they use, while four workers identified using between two to four tools each, which is why the number of tools exceeds the number of participants.

### ***Assessment Tools' Purpose of Use***

Why participants use their assessment tool(s) to work with their clients/patients



**Figure 1**

*Figure 1* shows participants' responses when asked what purposes the assessment tool(s) they used serve for their clients/patients. Some participants identified multiple purposes of the assessment tool(s) they used, while some identified one purpose. The values in each pie slice indicate the number of participants who identified the corresponding purpose as being fulfilled by their primary assessment tool(s). The "other" category of this chart represents the following answers: "clients well-being", "assess symptomology and screen for group treatment", "to determine severity of depressive symptoms", "Outcome measure re: effectiveness of treatment", "To assess for safety risk", "screening for distress... could lead to diagnosis", "To measure severity of depression symptoms", and "Discharge planning". Answers in the "other" category were grouped together as they were highly varied, and generally not precisely attributable to

any other category. Overall, it seems that the primary purposes of assessment tools used by participants are to assess clients'/patients' safety risk and to refer them for service.

***Assessment Tools' Engagement with Issues Relevant to Mental Health***

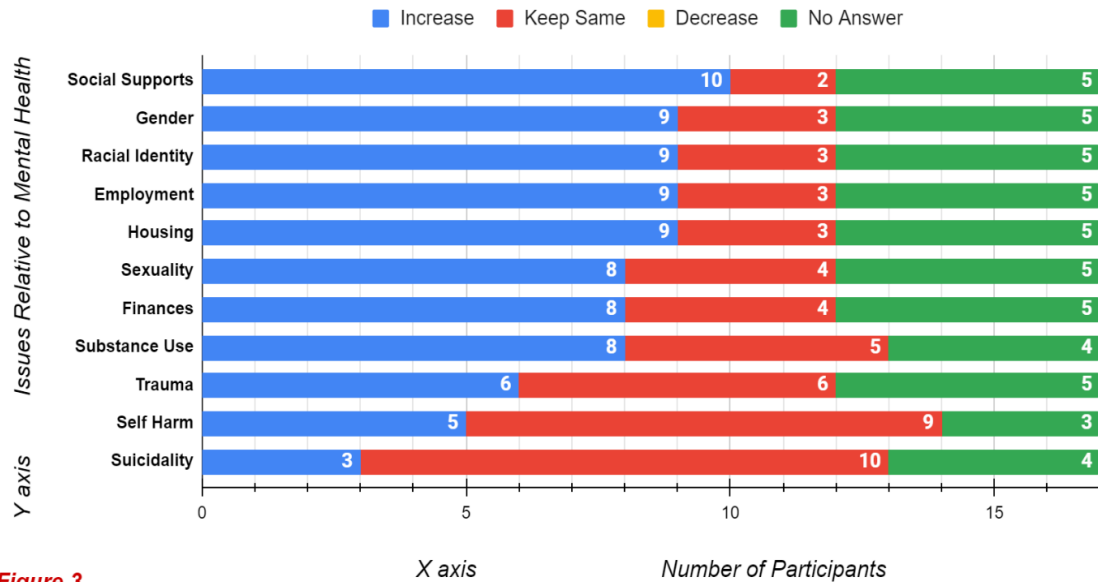
Issues:	Degree to which participants believe their primary assessment tool(s) engage with each issue:																
	1 = not at all      10 = thoroughly																
Suicidality	1	10	9	9	4	6	8	10	6	1	10	1	10	3	10		10
Self-Harm	1	10	8	8	2	1	8	10	6	1	10	1	10	3	9		10
Social Supports	8	5	1	7	2	1	1	6	5	6	6	8		1	5		2
Trauma	1	1	1		10	1	10	5	1	1	10	1		3	10		2
Substance Use	1	5	1	7	1	1	1	5	1	1		1	10	3	10		10
Finances	9	1	1	1	1	1	1	3	1	1	6	9		1	5		2
Housing	9	1	1	1	1	1	1	3	1	1		10		1	5		2
Employment	1	1	1	1	1	1	1	3	1	1		1		1	5		2
Gender	1	2	1	1	1	1	1	1	1	1		1		1	5		2
Sexuality	1	2	1	1	1	1	1	1	1	1		1		1	2		2
Racial Identity	1	2	1	1	1	1	1	1	1	1		1		1	2		2

*Figure 2*

Participants were asked to identify the extent to which the primary assessment tool(s) they used engaged with the following issues: Substance Use, Trauma, Suicidality, Self-Harm, Gender, Sexuality, Racial Identity, Employment, Housing, Finances, and Social Supports. They were asked this to establish assessment tools' current engagement with these issues to later compare to data about how assessment tools *should* engage with these issues. They were asked to select from a scale of "1" (indicating that the issue was not engaged with at all) to "10" (indicating that the issue was thoroughly engaged with). These results are shown in *Figure 2*, with each number representing one participant's answer. Each participant could only select one scaling number per issue. Empty spaces indicate a participant not scoring that issue. One column is entirely empty, as that participant did not answer these questions at all. Of all the issues included in the survey question, substance use, trauma, suicidality, self-harm, and social supports were identified as being most engaged with, as they frequently have far higher numbers compared to other issues. Overall, suicidality and self-harm seem to have the highest frequency of high scores, with most participants scoring these issues as "8" or higher, indicating that they are extensively engaged with in the assessment tool(s) they use. Exceptionally low engagement scores were frequently observed in response to gender, sexuality, racial identity, and employment categories. A majority of participants scored these issues with "1", while the remainder of scores ranged from "2" to "5", indicating that generally, participants believe the assessment tools they use do not engage with these issues at all.



Participants' responses when asked if their assessment tool(s) should change the amount of engagement they have with each issue



**Figure 3**

The high frequency of low scores in *Figure 2* indicates participants' beliefs that the assessment tool(s) they use scarcely engage with many of these issues. With this data alone, it is unclear if participants think it is *appropriate* for the assessment tool(s) they use to scarcely engage with so many biopsychosocial issues. To determine participants' beliefs regarding the extent to which the assessment tool(s) they use should change their current content, participants were asked if they thought that the assessment tool(s) should have their engagement with each issue increased, decreased, or kept the same. *Figure 3* shows their responses, with the *X axis* representing the total number of all participants' responses to each issue. Each stacked bar corresponds to one of the issues located on the *Y axis*. The numbers within each bar indicate the number of participants who selected

that answer. For each issue located on the *Y axis*, each participant could only select one answer from the following options: increase, keep same, decrease, no answer. For example, the issue of “social supports” shows 10 participants answering to “increase” content, two participants answering to keep the amount of content the same, and five participants selecting “no answer”. While most participants provided answers regarding each issue in *Figure 2*, nearly a third of participants did not answer questions regarding many issues in *Figure 3*. Therefore – compared to data about how much issues *should be* engaged with – approximately five more participants contributed to the data regarding the extent to which certain issues *are currently* engaged with in the assessment tool(s) they use.

Due to a total of zero participants answering “decrease”, results show that – aside from participants who did not answer – they unanimously identify that they believe the assessment tools’ engagement with all of these issues should not be decreased at all. Exempting those who selected “no answer”, remaining scores show that over half of participants identified that the assessment tools they were using should increase engagement with all issues except for trauma, suicidality, and self-harm. The seven issues that participants scored lowest regarding current engagement in *Figure 2* (i.e., “substance use”, “finances”, “housing”, “employment”, “gender”, “sexuality”, and “racial identity”) have majority votes for increasing engagement in *Figure 3*. Meanwhile, the two issues which scored highest on current engagement in *Figure 2* (i.e., “suicidality” and “self-harm”) were given majority votes to be kept the same in *Figure 3*. Social supports was the one issue with frequently moderate to high scores in *Figure 2* as well as

a majority of votes to have content increased in *Figure 3*. Furthermore, social supports had the highest number of votes in favour of increasing content, with 10 participants indicating more content was needed and only two indicating there was already enough content.

The generally low scores related to the assessment tools’ engagement with many issues in *Figure 2* resulted from many participants answering “1”, indicating that, from their perspective, the corresponding issue is not addressed at all in the assessment tool(s) they use. When this is considered in comparison to the majority of votes for increase in *Figure 3*, it suggests that participants believe these issues should be included in assessment tools where they are entirely absent.

Responses from participants who use tools to asses for safety when asked if their assessment tool(s) should change the amount of engagement they have with each issue

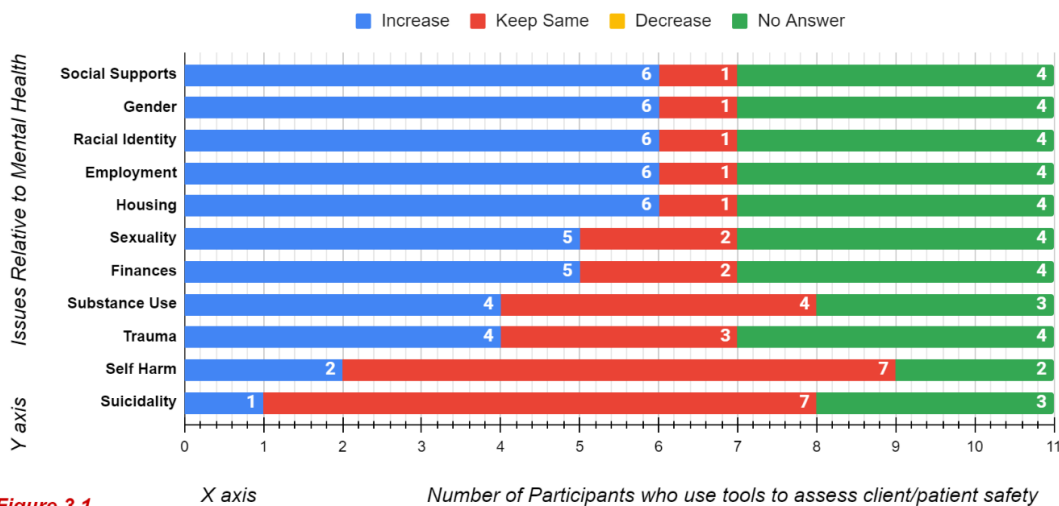


Figure 3.1

*Figure 3.1* shows responses exclusively from the 11 participants who indicated that they primarily use assessment tool(s) to assess for clients'/patients' safety. Like in *Figure 3*, these are participants' responses when asked if they thought that the assessment tool(s) they use should have their engagement with each issue increased, decreased, or kept the same. This data is intended to determine participants' beliefs regarding the extent to which the assessment tool(s) they use should change their current content. As shown in *Figure 3.1*, the *X axis* represents the total number of all participants' responses in relation to each issue. Each stacked bar corresponds to one of the issues located on the *Y axis*. The numbers within each bar indicate the number of participants who selected that answer. For each issue located on the *Y axis*, each participant could only select one answer from the following options: increase, keep same, decrease, no answer. Exempting those who selected "no answer", *Figure 3.1* shows that amongst these participants there is still a majority of votes in favour of increasing all issues aside from suicidality and self-harm. This implies that participants believe that the assessment tools they use to assess client/patient safety may benefit from the inclusion of more content engaging with other issues.

### ***Time to Complete Assessments***

Time Had Vs. Time Needed to Complete Assessment

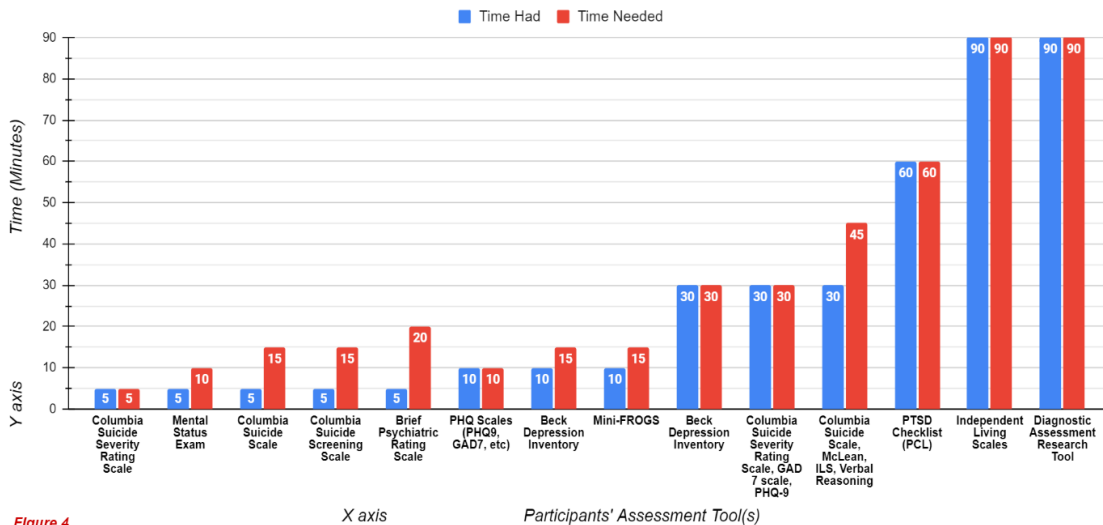


Figure 4

To gain insight into the amounts of time participants feel they need in order to properly use their respective assessment tool(s), participants were asked to submit the number of minutes they currently have to complete assessment tools, as well as the number of minutes they feel are necessary to complete them. Of the 17 participants' responses to this question, only 14 have been analyzed due to three responses being incomplete.

The *X axis* shows the primary assessment tools used by the 14 participants. Three participants indicated primary use of more than one assessment tool. The *Y axis* shows time measured by minutes. Each blue bar represents the amount of time a participant indicated they have to complete the assessment tool(s) they use, while each red bar represents the amount of time a participant believes they *need* to complete the assessment tool(s) they use. As these results show in *Figure 4*, most participants who indicated that they have 10 minutes or less to complete assessment tools also indicated a need for more

time to do so. Of the tools that participants were given between five to 10 minutes to complete, tools that were indicated as needing more time to complete were the following: Mental Status Exam (n=1), Columbia Suicide Scale (n=2), Brief Psychiatric Rating Scale (n=1), Beck Depression Inventory (n=1), and Mini-FROGS (n=1). Of the three participants who have to complete assessment tools in 10 minutes, only one participant – who uses “PHQ Scales (PHQ 9, GAD 7)” – indicated having enough time while the remaining two indicated needing five minutes more. Of the five participants who have to complete assessment tools in five minutes, only one participant – who uses the Columbia Suicide Severity Rating Scale - indicated having enough time while the remaining four indicated needing between double to triple the amount of time they are given to conduct assessments using their respective tools. Overall, six of the eight participants who indicated having 10 minutes or less to complete assessment tools also indicated needing more time. In contrast, of the six participants who indicated having 30+ minutes to complete assessment tools, only one participant – who indicated using “Columbia Suicide Scale, McLean, ILS, Verbal Reasoning” – also expressed the need for more time. This implies participants believe that five to 10 minutes may not generally be enough time to complete the assessment tool(s) they use, while 30+ minutes is often enough time. None of the participants indicated needing less time to use their respective assessment tool(s), implying that having excess time to complete assessment tools is often a non-issue.

Time Had Vs. Time Needed to Complete Assessment by Participants who Assess for Client/Patient Safety

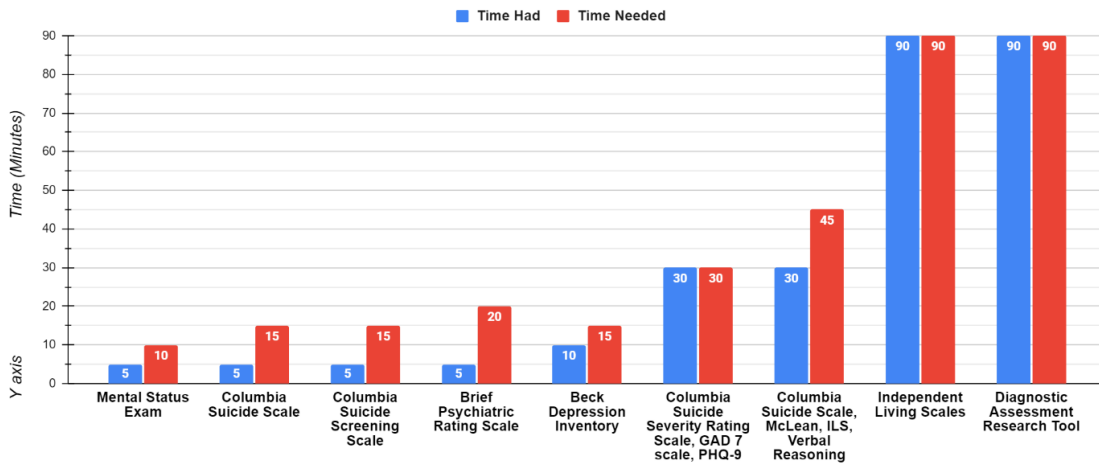


Figure 4.1

X axis

Assessment Tools of Participants who Assess Client/Patient Safety

Figure 4.1 shows responses exclusively from nine participants who indicated that they primarily use assessment tool(s) to assess for clients'/patients' safety. Two participants who primarily assess client/patient safety did not provide complete answers regarding time, therefore their answers are exempt. Like in Figure 4, these are participants' responses when asked to submit the number of minutes they currently have to complete assessment tools, as well as the number of minutes they feel are necessary to complete them. This data is intended to provide insight into the amounts of time participants feel they need in order to properly use their respective assessment tool(s). The X axis shows the primary assessment tools used by the nine participants, two of which indicated primary use of more than one assessment tool. The Y axis shows time measured by minutes. Each blue bar represents the amount of time a participant indicated they have to complete their assessment tools, while each red bar represents the amount of time a participant believes they *need* to complete their assessment tools.

Overall, the data reflects a similar pattern to answers from *Figure 4*. That is, when examining time use and needs exclusively from participants who primarily assess for safety, it remains apparent that workers may have between five to 90 minutes to complete assessment tools, may need double to triple the amount of time when given five to 10 minutes, and often do not need extra time when given 30-90 minutes.

The tools that were indicated as needing more time to complete were the following: Mental Status Exam (n=1), Columbia Suicide Scale (n=3), Brief Psychiatric Rating Scale (n=1), and Beck Depression Inventory (n=1). The one participant – who uses “Beck Depression Inventory” – who has ten minutes to complete this assessment tool indicated needing an extra five minutes to do so. All four participants who have to complete assessment tool(s) in five minutes indicated needing between double to triple the amount of time they are given to conduct assessments using the respective tools they indicated using: Mental Status Exam (n=1), Columbia Suicide Screening Scale (n=2), Brief Psychiatric Rating Scale (n=1), and Beck Depression Inventory (n=1). Overall, all five participants who indicated having 10 minutes or less to complete assessment tools also indicated needing more time. In contrast, only one of the four participants who indicated having 30+ minutes to complete assessment tools also expressed the need for more time. This participant indicated using “Columbia Suicide Scale, McLean, ILS, Verbal Reasoning”. This implies that these participants believe that five to 10 minutes may not generally be enough time to complete the assessment tool(s) they use, while 30+ minutes is often enough time. Overall, the data from *Figures 4* and *4.1* indicates that



participants believe that issues with time management are similarly present amongst both safety assessment tools and assessment tools in general.

***Assessment Tools’ Engagement with Strengths/Values and Problems/Deficits***

Participants’ responses when asked how much their assessment tool(s) engage with clients’/patients’ strengths and values VS. clients’/patients’ problems and deficits

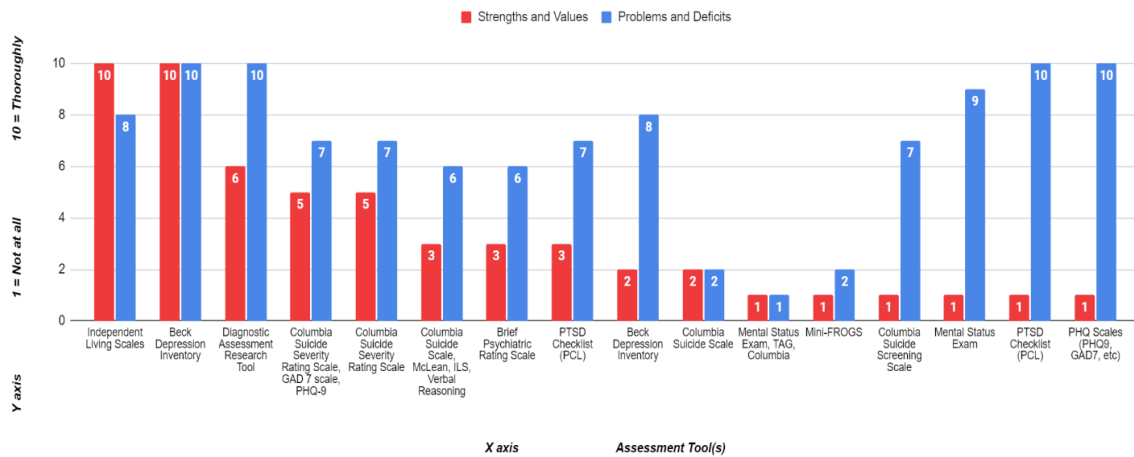
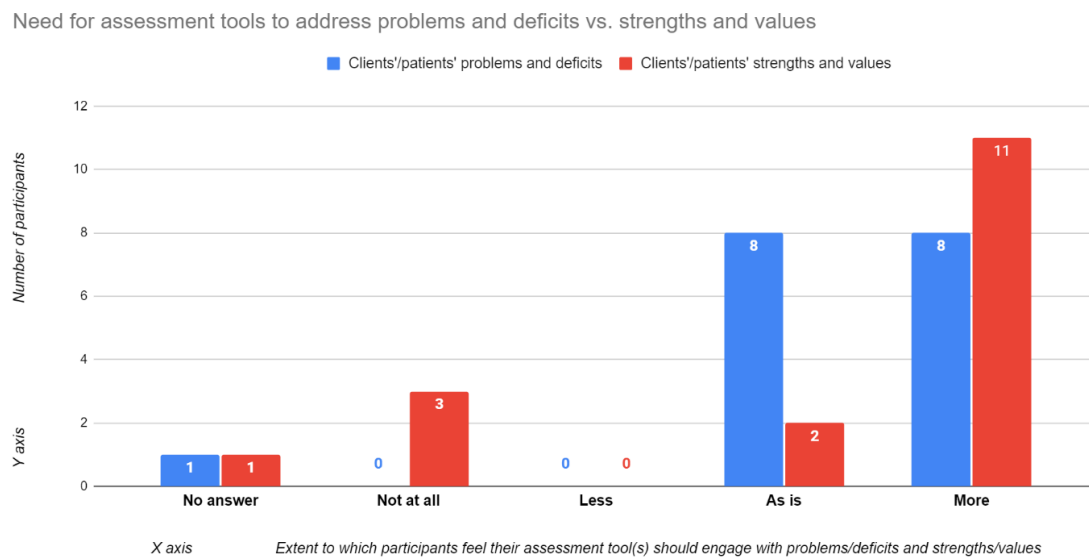


Figure 5

To gain insight into participants beliefs regarding the balance of strengths/values and problem/deficit oriented content in the assessment tools they use, they were asked to scale how much the assessment tool(s) they use engage with the strengths/values and problems/deficits of their clients/patients. Their responses are shown in *Figure 5*. One of the 17 participants did not submit a complete answer, so only 16 responses are shown. Four of the 16 participants who responded indicated using between two to four different assessment tools. The *X axis* represents the tools participants identified using. The *Y*

*axis* represents a scale from “1” - “10”, with “1” meaning “not at all” and “10” meaning “thoroughly”. The red bars represent answers regarding strengths and values, while the blue bars represent problems and deficits. The content of *Figure 5* will be further discussed alongside content from *Figure 6* below.



**Figure 6**

To understand how participants feel about changing the extent to which the assessment tool(s) they use engage with both strengths/values and problems/deficits, they were asked if they thought engagement should not occur at all, be decreased, kept as is, or increased. One participant chose not to answer, while the remaining 16 participants answered this question. *Figure 6* shows their responses to this question. The *Y axis* represents the number of participants, while the *X axis* represents the five answers they

could choose from. The blue bars represent answers regarding problems and deficits, while the red bars represent answers regarding strengths and values.

I will first report on the results of *Figures 5* and *6*, regarding “strengths and values”. Of the 16 responses shown in *Figure 5*, 11 responses score between “1” and “3”. These 11 participants indicated using the following assessment tool(s): Columbia Suicide Scale (n=4), “McLean” (n=1), “ILS” (n=1), “Verbal Reasoning” (n=1), Brief Psychiatric Rating Scale (n=1), PTSD Checklist PCL (n=2), Beck Depression Inventory (n=1), Mental Status Exam (n=2), “TAG” (n=1), “Mini-FROGS” (n=1), and “PHQ Scales (PHQ 9, GAD 7, etc.)” (n=1). Overall, this indicates that the majority of participants believe that content about strengths and values is scarcely present in the aforementioned assessment tools they use. *Figure 6* shows that 11 out of 16 participants indicate that the assessment tool(s) they use should increase their engagement with clients’/patients’ strengths and values. One of these 11 participants did not indicate which assessment tool they use, while four of the remaining 10 participants indicated using between two to four tools. These 10 participants indicated using the following assessment tool(s): Columbia Suicide Scale (n=4), “McLean” (n=1), “ILS” (n=1), “Verbal Reasoning” (n=1), Brief Psychiatric Rating Scale (n=1), Beck Depression Inventory (n=2), Mental Status Exam (n=2), “Mini-FROGS” (n=1), and Diagnostic Assessment Research Tool (n=1). Aside from PTSD Checklist PCL (n=2), “PHQ Scales (PHQ 9, GAD 7, etc.)” (n=1), Diagnostic Assessment Research Tool (n=1), and Beck Depression Inventory (n=1), the remaining tools identified as having low engagement with strengths/values are the same tools that are also identified as needing increased

engagement with strengths/values. Therefore, both the number of participants and the number and variety of assessment tools are similar in their indication that strengths/values oriented content should be engaged with more.

I will now discuss the results of *Figures 5* and *6* regarding “problems and deficits”. Of the 16 responses shown in *Figure 5*, 13 responses were scored between “6”-“10”, with the remaining three responses being scored between “1”- “2”. The 13 participants who scored current engagement with problems/deficits between “6”-“10” indicated using the following assessment tool(s): Columbia Suicide Scale (n=4), “McLean” (n=1), Independent Living Scales (n=2), “Verbal Reasoning” (n=1), Brief Psychiatric Rating Scale (n=1), PTSD Checklist PCL (n=1), Beck Depression Inventory (n=1), Mental Status Exam (n=2), “TAG” (n=1), “Mini-FROGS” (n=1), and “PHQ Scales (PHQ 9, GAD 7, etc.)” (n=1), Brief Psychiatric Rating Scale (n=1), and Diagnostic Assessment Research Tool (n=1). Overall, this indicates that a majority of participants believe that content about problems and deficits is generally present in the aforementioned assessment tools they use.

*Figure 6* shows that half of participants (8) believe that the amount of content regarding clients’/patients’ problems and deficits should be left as is, while the other half of participants believe this content should be increased. One participant did not indicate which assessment tool they use. The remaining seven participants who feel that the assessment tool(s) they use should increase problem/deficit oriented content use the following tools: Columbia Suicide Scale (n=2), “McLean” (n=1), Independent Living Scales (n=2), “Verbal Reasoning” (n=1), Brief Psychiatric Rating Scale (n=1), Beck

Depression Inventory (n=1), “Mini-FROGS” (n=1), and Brief Psychiatric Rating Scale (n=1). Aside from PTSD Checklist PCL (n=1), “PHQ Scales (PHQ 9, GAD 7, etc.)” (n=1), Mental Status Exam, (n=2), “TAG” (n=1), and Diagnostic Assessment Research Tool (n=1), the remaining tools identified as having moderate to high engagement with problems/deficits (Columbia Suicide Scale (n=2), “McLean” (n=1), Independent Living Scales (n=2), “Verbal Reasoning” (n=1), Brief Psychiatric Rating Scale (n=1), Beck Depression Inventory (n=1), “Mini-FROGS” (n=1), and Brief Psychiatric Rating Scale (n=1)) are also identified as needing increased engagement with problems/deficits.

When comparing the data, there seems to be a correlation between the degree to which participants believe problems and deficits are already included in the assessment tools they use and how much they should be included. That is, most participants selected mid to high scores for current engagement with problems and deficits, indicating they are engaged with ranging from moderately to thoroughly. Similarly, participants gave equal responses for leaving these tools as is and for increasing problem/deficit oriented content. Therefore, it seems participants feel that the assessment tools they use moderately engage with problems/deficits and are in moderate need of increase.

There are no responses indicating that content about problems, deficits, strengths, and values should be decreased in assessment tools. However, three participants answered that the assessment tools they identified using (“PHQ Scales (PHQ 9, GAD 7, etc.)” (n=1), Columbia Suicide Screening (n=2), “MSE” (n=1), and “TAG” (n=1)) should not engage with strengths and values at all. Despite this, the overall sentiment to decrease this content was extremely low, indicating that the participants believe that

content about strengths/values and problems/deficits should at the very least be maintained if not increased in the assessment tools they use.

## CHAPTER 6: DISCUSSION

### *Introduction*

The purpose of this chapter is to discuss the possible implications of healthcare workers' beliefs about the assessment tools they use regarding the amount of time it takes to use them and the extent to which they engage with clients'/patients' strengths/values, problems/deficits, and biopsychosocial issues. As this chapter will discuss participants' opinions on assessment tool issues, it is important to consider what they indicated that these tools are intended to achieve. That is, participants identified the two most common purposes of their respective assessment tool(s) to be safety assessment and service referral. Approximately half of participants indicated these purposes, while approximately a quarter of participants indicated diagnosis and goal establishment as purposes of the assessment tool(s) they use. Therefore, the low engagement with certain issues identified between the assessment tools used by participants' may not be equally relevant. For example, *Figure 2* shows that suicidality and self-harm are the most common issues engaged with by the assessment tools used by participants. Seven out of ten participants who identified that the assessment tools they use have high engagement with suicidality and self-harm, also identified safety assessment to be a primary purpose of their tools, therefore it is reasonable that they frequently indicated suicidality and self-

harm to be engaged with. Regarding issues that are identified as being scarcely engaged with, this chapter will explore the necessity of increasing or including respective content in assessment tools where it is currently absent. This chapter will do this by discussing the possible implications of participants' survey responses and will connect these implications to relevant literature to discuss some reasons why underrepresented issues should be more extensively engaged with in assessment tools.

### ***Time Limitations for Assessment Tool Use***

As participants identified in *Figure 4*, they believe they need between 2x-3x more time to complete assessment tools of which they are currently given five to 15 minutes to complete. In contrast, the majority of participants identified that they do not need extra time to complete assessment tools for which they are currently given 30-90 minutes to complete. *Figure 4.1* shows that results are similar when exclusively accounting for participants who assess client/patient safety. According to Smith, budget cuts in Ontario are to blame for social workers' increased demand to do more with less (2011).

Regarding safety assessments, Hart (2014) and Kene, Yee, and Gimmestad (2019) explain that healthcare practitioners are also likely to be impacted by time restraints and expectations for assessments to be thoroughly documented. That is, healthcare workers and social workers may be expected to increase the number of clients they can see, while necessitating decreasing the amount of time they can spend with each client.

Smith explains that with time restraints come assessment tools that may be standardized to the extent that they are inconsiderate of many unique and personal factors

service users may have (2011). Both Smith (2011), and Kene and colleagues (2019) explain that inadequate time for assessment can result in missed opportunities to create a trusting working relationship, overall impacting assessment and treatment. Although the survey did not ask participants to answer how they felt time impacted their service, implications may be made as seven participants did indicate needing more time. That is, participants may have indicated needing more time for assessments because they recognize that insufficient time does not allow for a worker-client/patient connection and/or comprehensive consideration for clients'/patients' personal issues and experiences. This seems reasonable considering that participants indicated - as discussed below - that the assessment tools they use need to more extensively engage with a greater variety of clients'/patients' issues.

### ***Engagement with Psychosocial Issues***

The data from *Figure 2* shows to what extent the participants think the assessment tool(s) they use engage with a variety of issues that may be relevant to mental health. When looking at the data from *Figure 3*, which shows if participants think these issues should be engaged with more, less, or the same, implications can be made about the extent to which certain assessment tools should be altered to engage with these issues differently. From there, further implications can be made regarding the potential effects of such alterations. In what follows, I will discuss the four issues that participants identified as being least engaged with in the assessment tools they use.

### ***Racial Identity***



*Figure 2* shows that racial identity and sexuality are the issues least engaged with amongst all the assessment tools used by participants. Of the 14 responses indicating the extent of engagement with racial identity, 11 participants answered “1” indicating it is not engaged with at all, while the remaining three participants answered “2”, indicating it is almost non-existent in the assessment tools they use. In *Figure 3*, nine participants answered that racial identity should be engaged with more, while only three participants answered that it should remain the same and none answered it should be decreased. Therefore, from the data from *Figures 1* and *2*, it may be suggested that – excluding participants who selected “no answer” – most participants believe that racial identity is not engaged with at all in the assessment tools they use and should be included. This data could imply that these participants feel that their respective assessment tools’ lack of consideration for racial issues are resulting in suboptimal service for this population. Considering that racial minorities are reported to be more likely to fear and avoid seeking professional help with mental health issues because of a history of institutional oppression that continues today (e.g., people of colour having less access to proper diagnoses, potential for healthcare providers to have racial bias) (Moreland-Capuia, 2021), lack of consideration for racial issues in assessment tools may be understood to contribute to this fear, or to at least avoid addressing it (Chang & Downey, 2012; HHS, 2001). From a humanistic perspective, healthcare should be inclusive of attention to racial differences because clients/patients should be treated with consideration for their personal identities and experiences – especially those related to oppression and discrimination (Hategan et al., 2020). Therefore, humanism, which asserts that optimal

care for clients/patients is achieved when they are engaged with as individuals, would argue that engagement with race is essential in providing effective healthcare (Hategan et al., 2020).

### *Sexuality*

Alongside racial identity, sexuality was most frequently scored by participants as an issue least engaged with in the assessment tools they use. That is, the majority of participants (11) answered that sexuality was not engaged with at all. *Figure 3* shows that eight participants answered that content about sexuality should be increased, while four answered that content should be kept as is and zero answered that it should be decreased. Overall, this indicates that – excluding participants who did not answer - two thirds (eight out of 12) of participants are in favour of increasing content about sexuality. Therefore, between the answers from *Figure 2* (which shows the extent to which participants believe the assessment tools they use currently engage with each issue) and *Figure 3*, the majority of participants report that sexuality is scarcely engaged with in the assessment tools they use, and that content about sexuality should be increased. This implies that participants feel that the assessment tools they use may better assess amental health concerns experienced by LGBTQ2S+ people by increasing engagement with sexuality. Seeing how people with non-conforming sexual identities are reported to be more likely than heterosexual people to experience trauma, suicidal ideation, and substance use as a result of societal and social prejudice and sexual demonization, it seems reasonable to consider that lack of engagement with sexuality in assessment tools may result in healthcare workers being less informed about the impacts of these factors

on mental health (Bostwick & Harrison, 2020; DiPlacido & Fallahi, 2020). If an assessment tool is not discussing sexuality, then perhaps it will be less likely to properly recognize many issues relative to clients'/patients' experiences with sexual prejudice. Using a humanistic approach, an assessment tool would involve such consideration for the sexual identity of clients/patients, recognizing their unique experiences as being directly related to their health (Hategan et al., 2020). From a systems perspective, it seems apparent that many people identifying as LGBTQ2S+ are impacted by the effects of societal and social exclusion (Schirmer & Michailakis, 2019). The LGBTQ2S+ community is stigmatized by society to the extent that many people feel they must hide their sexual identities for fear of social repercussions (DiPlacido & Fallahi, 2020). Even in small systems such as family, LGBTQ2S+ people are often stigmatized and even rejected - isolated by their parents, the very people meant to protect and support them most (DiPlacido & Fallahi, 2020), making it especially significant for the assessment tools use by healthcare workers to engage with their sexuality and the experiences associated with it.

### ***Gender***

As with sexuality and racial identity, *Figure 2* shows that assessment tools' engagement with gender was scored as "1" by a majority of participants. Excluding three participants who did not answer, 11 out of 14 participants scored gender as "1", while the remaining three participants scored gender between "2" - "5". This indicates that gender engagement is entirely absent in the assessment tools used by 11 out of the 14 participants who answered. Excluding five participants who did not answer to what

extent the assessment tool(s) they use should engage with gender, *Figure 3* shows that nine out of the remaining 12 participants believe that content about gender should be increased. The inclusion of gender in assessment tools seems necessary, as gender is closely linked to relative experiences of prejudice and abuse - both experiences known to negatively impact mental health (Kuper et al., 2020; WHO, 2005). For example, when assessing men, it may be essential for assessment tools to ask questions relative to gender because they may lead to a conversation about common gender-related issues experienced by men, such as experiences repressing emotions and internalizing trauma (WHO, 2005; MHCC, 2012). Likewise, when assessing women, it may be essential for assessment tools to ask gender-related questions to motivate discussion about gender-related issues experienced by females, such as being victims of physical violence (WHO, 2005) and/or being diagnosed with 'mental illness' without consideration for gender-related issues attributable to sexism and patriarchy (Tseris, 2019). This is where it seems necessary for assessment tools to approach a humanistic perspective, creating opportunities to hear clients'/patients' individual experiences and stories to understand how such experiences are connected to their mental health symptoms (Kogstad, Ekeland, & Hummelvoll, 2011). With such an approach, a transgender person may be assessed with consideration for their lived experiences with gender identity, and that knowledge may be relevant when considering their experience with mental illness. It is also important to consider systems in relation to gender. For example, transgender people are more likely than biological men and women to have difficulties in accessing proper healthcare as a direct result of the responses of the healthcare system to their gender

(Dickey, 2020). Therefore, transgender people may find themselves marginalized by the healthcare system. Considering this, it seems necessary for assessment tools to consider systems as they may affect clients/patients differently in relation to their identities.

### ***Employment***

*Figure 2* shows employment to be another issue that was scored as “1” for assessment tool engagement by a majority of participants. Excluding three participants who did not answer, 11 participants scored employment as “1”, while the remaining three scored it between “2” - “5”. *Figure 3* shows that – excluding the five participants who did not answer – nine out of 12 participants indicated that content about employment should be increased in the assessment tools they use. Therefore, data between *Figures 2 and 3* shows that most participants who answered the two questions related to employment feel that the assessment tools they use should engage with employment, while they currently do not at all.

For people with mental health issues, obtaining properly paying employment can be extremely difficult because of systemic barriers that can prevent them from accessing and completing education or from building work skills (CMHAO & CAMH, 2010; Hirdes et al., 2020; MHCC 2012). This means that someone with mental health issues is less likely to have secure housing and/or social networks, increasing the likelihood that their existing mental health issues will worsen (CMHAO & CAMH, 2010; Leach, 2014; Munn-Rivard, 2014). This correlation between employment and mental illness highlights

the importance of including questions about employment in tools used to assess people with mental health issues.

### ***Psychosocial Issue Engagement in Relation to Self-Harm and Suicidality***

Due to the majority of participants indicating that the assessment tools they use are primarily intended to assess for clients'/patients' safety, in this section I will discuss a possible correlation between psychosocial issues and self-harm/suicide. To do so, I will speak to data emerging from the survey as well as relevant research literature. As participants' answers have indicated, all issues addressed in *Figure 3* - aside from suicidality and self-harm - need to be engaged with more in the assessment tools they use.

*Figure 3.1* shows that overall, participants who primarily use assessment tools to assess for client/patient safety believe that these same tools should increase engagement with psychosocial issues as well. Why might participants indicate that the assessment tools they use should ask questions about issues like racial prejudice or substance use when these tools are primarily intended to assess for clients'/patients' safety (i.e., the risk they will harm or kill themselves)? Drawing on the literature and data from *Figure 2*, in this section I will show how self-harm and suicidality may be correlated to all the issues that *Figure 2* shows are scarcely included in the assessment tools used by participants. Before discussing these correlations, I want to make it clear that I am not implying the issues below to be caused by mental health issues. Furthermore, I am not saying that all people who experience issues such as poverty and trauma are at increased risk for self-harm or suicide. Rather, I am showing that psychosocial issues – which exist

in the societal context of racism, heterosexism, ableism, sexism, and sanisim – *may* be related to increased risk for self-harm or suicide, meaning it may be beneficial for safety assessment tools to more fully engage with psychosocial issues when working with people who are at risk of self-harming or attempting suicide.

People experiencing inadequate housing or homelessness are reported to be more likely to abuse substances, self-harm, and complete suicide (Munn-Rivard, 2014). People identifying as transgender or gender non-binary are reported to be more likely to self-harm and have suicidal ideation (Dickey, 2020; Kuper, Bismar, & Ryan, 2020). Compared to cisgender individuals, those identifying as LGBTQ2S+ more frequently experience mental health issues and thoughts of suicide (DiPlacido & Fallahi, 2020). Living in poverty is known to increase one's likeliness of completing suicide (Kerr et al., 2017). Having a supportive family can protect someone from contemplating or completing suicide, while having non-supportive familial relationships can worsen the risk of suicide (Bell, 2021). Both exposure to trauma and post-traumatic stress disorder are associated with increased suicidality and suicide completion (Bryan, 2016; Forray & Yonkers, 2021). People with substance use disorders are also reported to be more likely to contemplate or complete suicide compared to those without (Forray & Yonkers, 2021). Compared to those who are employed, people who are unemployed are at a higher risk for attempting or completing suicide (Shand, Duffy, & Torok, 2021). In Canada, Indigenous people are far more likely to complete suicide or experience suicidal ideation compared to non-Indigenous people (Mihychuk, 2017).

As the aforementioned literature shows, it may be suggested that self-harm and suicide can be closely correlated to each of the psychosocial issues – and the relevant social factors that work to oppress some while also privileging others – discussed in this thesis. I believe it is reasonable then to assume that the majority of participants shown in *Figure 3.1* were in favour of having engagement with psychosocial issues increased in assessment tools because they recognize - as the literature suggests - that holistically assessing biological, psychological and social issues may be necessary to more accurately understand their clients’/patients’ risk to self-harm or attempt suicide (Knapp, 2020).

#### ***Engagement with Strengths/Values and Problems/Deficits***

As the data from *Figure 5* shows, a majority of participants indicated that the assessment tools they use moderately to thoroughly engage with clients’/patients’ problems/deficits. In comparison, *Figure 6* shows that participants were equally divided in their indications that the assessment tools they use should maintain or increase engagement with clients’/patients’ problems/deficits. *Figure 5* shows that a majority of participants indicated that the assessment tools they use engaged with strengths and values scarcely or not at all. In comparison, *Figure 6* shows that a majority of participants indicated that the assessment tools they use should address strengths/values more.

Overall, data from *Figures 5* and *6* implies that participants believe problems and deficits are moderately addressed in the assessment tools they use, and are in moderate need of increase, while they believe strengths and values to be insufficiently addressed



and in much need of increase. The participants' responses regarding problems/deficits and strengths/values seem to be consistent with studies by CPBC (2017) and Wand and colleagues (2020). That is, like the small sample of participants in this study, both CPBC (2017) – with a sample of 69 respondents - and Wand and colleagues (2020) indicate that in the Champlain region of Ontario, and in Australia/New Zealand respectively, most assessment tools are problem/deficit oriented despite evidence that it may be necessary for assessment tools to incorporate a strengths approach. As a majority of the participants in this study indicated using assessment tools to assess client/patient safety, one possible interpretation could be that they believe that the inclusion of strengths/values oriented content may improve assessment tools used for self-harm and/or suicide. As shown in *Figure 6.1*, there is support for assessment tools to engage with clients'/patients' strengths and values is shown amongst many participants who use assessment tools to assess for clients'/patients' safety.

### ***Holistic Assessment***

Overall, survey participants indicated they believe that the assessment tools they use are in need of more content related to most of the biopsychosocial issues discussed in this thesis. Furthermore, none of the participants indicated that content about any of these issues should be decreased in the assessment tools they use. While the issues of self-harm and suicide were not generally indicated by participants as needing increases in assessment tool content, they too were never indicated as needing to be decreased. Participants' responses regarding problem/deficit and strengths/values content may also imply their desire for holistic assessment. Participants generally indicated that the

assessment tools they use sufficiently engaged with problems/deficits, and that this degree of engagement with problems/deficits should be left as is or increased. Furthermore, participants generally indicated that the assessment tools they use scarcely engaged with strengths/values, and that engagement with these should be increased. Participants' answers regarding both problems/deficits and strengths/values would seem to imply their approval of both orientations. That is, participants indicated that it is necessary for assessment tools to engage with both clients'/patients' strengths/values and problems/deficits. Considering their answers about biopsychosocial issues, strengths/values, and problem/deficit oriented content, it seems that participants are supportive of assessment tools that engage with the whole person as opposed to a selection of issues or symptoms. Furthermore, as the participants' professional roles and purposes for using assessment tools varied, their support for biopsychosocial, strengths/values, and problem/deficit content implies that - in this sample - holistic assessment may be preferred for a variety of applications.

## **CHAPTER 7: CONCLUSION**

### ***Limitations***

This research was significantly limited in a variety of ways - many of which are the result of the COVID-19 pandemic and its impact on the Healthcare System in Ontario. This research was limited by an extremely low sample size, which resulted in

difficulties analyzing data and recognizing possible implications. Furthermore, the small participant sample made it impossible to compare this data with literature to identify potential trends. Rather, the research is limited to a nascent discussion of whether there is a need for greater attention to biopsychosocial issues in mental health assessment tools. Due to the small sample size of 17 participants, data from this study cannot be recognized to represent the Hamilton region, but rather, a small sample of St. Joseph's Hamilton Healthcare workers.

The research sample was diverse in that it was composed of healthcare workers from inpatient, outpatient, emergency, and community branches. However, the sample was limited in its composition of social workers, occupational therapists, nurses, and psychologists. That is, this sample did not consider perspectives from other relevant healthcare professions such as doctors, psychiatrists, and counselors. Therefore, the already limited sample could not be discussed as representing all major healthcare professions.

The variety of assessment tools used by participants limited the extent to which specific tools could be discussed in relation to other factors. That is, many participants indicated primary use of multiple assessment tools despite being asked to only identify one tool (See Appendix A). As a result, many of their responses could not be fully attributed to one tool, resulting in significant limitations in analyzing and discussing potential consistencies or inconsistencies between specific assessment tools. Rather, this thesis was limited to analysing and discussing data in relation to the purposes which participants indicated using the assessment tools for.

As made apparent in the findings and discussion sections, some participants chose not to answer specific questions. This was allowed with consideration that participants may not be comfortable answering certain questions. As a result of some questions going unanswered, the entire sample of 17 participants could not be consistently analyzed in relation to each question, resulting in data originating from different groups of participants.

The research literature in this thesis was highly limited in its exclusion of literature that discusses the importance of the biomedical and problem/deficit oriented mental health assessment tools. That is, in this thesis I was focused on exemplifying some common gaps that may result from exclusive reliance on biomedical and problem/deficit oriented assessment tools. This thesis was also limited by my exclusion of critical literature discussing potential weaknesses with the psychosocial model and strengths/values approach in mental health assessment tools. Furthermore, in this thesis I focused on exemplifying ways in which the inclusion of the psychosocial model and strengths/values orientation in assessment tools may resolve some of the potential issues mentioned above. Lastly, this thesis did not include research about *service-users'* experiences and opinions regarding assessment tools and their potential for improvement.

As a result of COVID-19 and its resulting restrictions, access to research literature was limited almost exclusively to literature and resources found online. Furthermore, I was unable to ever meet in person with my supervisor, second reader, or the social work supervisor at St. Joseph's Healthcare Hamilton. As a result of the challenges of remote learning and remote communication, cooperation and collaboration were limited. This

limitation was likely worsened by my own stress and anxiety related to the mass death and panic caused by the COVID-19 pandemic. Certainly, the forced isolation as a result of multiple lockdowns combined with the uncertainty of having access to food and healthcare and the rational daily fear of loved ones getting seriously ill and dying resulted in some limitations to the capabilities of this thesis.

### ***Areas for Further Research***

I believe there are multiple findings from this small study that may benefit from further research. I think that the area in most significant need of further research is regarding healthcare workers' explanations for *whether* and *why* they think that the assessment tools they use may need more engagement with strengths/values and biopsychosocial issues. This research only asked healthcare workers the extent to which these issues were already included and the extent to which the workers felt they *should* be included. Although this research shows that some participants in this sample of healthcare workers appear to be in favour of strengths/values and biopsychosocial assessment, it does not explore why they believe this. Research into the reasons why healthcare workers favour these models may be necessary to explore the potential revision of assessment tools. Further research is also needed regarding the *extent* to which biopsychosocial issues and strengths/values should be incorporated into assessment tools. This research did not scale participants' answers regarding how much the assessment tools should be changed, it only asked them if certain issues should be increased, kept the same, decreased, or left out entirely. As a result, this research could not explore which biopsychosocial issues may have needed more engagement than

others. This is especially true in relation to issues that were indicated to be engaged with “not at all”. As most of the issues engaged with “not at all” were also indicated as needing to be increased, in this thesis I discussed my interpretation of this result to indicate participants' beliefs that these issues should be included in assessment tools in which they are absent. However, the absence of scaling answers resulted in the extent of increase being unknown. For example, scaled answers may have shown that most participants thought that content about gender should be increased thoroughly, while content about sexuality should only be slightly increased. Instead, across all issues, participants' answers simply indicated “increase”.

Further research is also needed regarding the opinions of service *users* regarding the need for more holistic assessment tools for mental health. Service users are the reason for this work entirely. This work revolves around their lived experiences, so naturally they have invaluable knowledge to be contributed to their assessment and treatment. Asking service users similar questions to those in the survey employed in this research may provide an intimate perspective on assessment tool use that may be necessary in making decisions on how to improve them.

### ***Concluding Remarks***

Overall, this research has shown - from the perspective of a small sample of healthcare workers - that some contemporary assessment tools may benefit from increasing their engagement with the strengths, values, and biopsychosocial issues of the people they are intended to assess. Furthermore, this research has discussed how

assessment tools' inadequate engagement with biopsychosocial issues may result in missed opportunities to understand clients/patients beyond the scope of their symptoms. Although the research sample was small, the findings of this thesis may contribute to further research regarding the content and holistic approaches of mental health assessment tools. This research may also contribute to further research regarding the significance of biopsychosocial issues in relation to mental health issues and assessment tools.

As this research has suggested, there appears to be some interest in changing the scope of some assessment tools - which have traditionally prioritized engagement with peoples' symptoms - towards formats that treat people with care for their unique and complex traits and experiences. Furthermore, towards assessment tools that are structured around the belief that all people have the power to contribute to their own recovery and wellbeing.

**APPENDIX**

*Appendix A*

**Survey Sent to St. Joseph’s Healthcare Hamilton Workers**

- 1. **What is your role?** Social Worker, Nurse, Occupational Therapist, Other: \_\_\_\_\_
- 2. **Type of Service:** (Community) (Inpatient) (Outpatient) (Emergency)
- 3. **What assessment tool do you use most often?** \_\_\_\_\_
- 4. **Is it mandated?** (YES) (NO) (UNSURE)
- 5. **Would you choose to use it if it was not mandated?** (YES) (NO)
- 6. **On average, how much time do you have to complete this tool with a client/patient?**  
\_\_\_\_\_ Minutes
- 7. **On average, how much time do you think is necessary for this tool to be effective with a client/patient?** \_\_\_\_\_ Minutes
- 8. **Why do you use this tool? Check all *that apply*.**

(To diagnose) (To refer for service) (To apply for housing) (To assess client safety)  
 (To assist with legal issues) (To establish goals for therapy) (To determine patient’s capacity to make treatment decisions) Other: \_\_\_\_\_

- 9. **How important is it for you to build rapport with a client/patient while you are using this tool?**

(1- Not important) (2) (3) (4) (5) (6) (7) (8) (9) (10-Essential)

- 10. **How does this tool affect your ability to build rapport with a client/patient?**

(1- Makes it difficult) (2) (3) (4) (5) (6) (7) (8) (9) (10-Helps Greatly)



**11. This tool should support you in building rapport with a client/patient:**

(MORE) (AS IS) (LESS) (NOT AT ALL)

**12. Does this tool assist clients/patients in receiving appropriate service?**

(1- Not at all) (2) (3) (4) (5) (6) (7) (8) (9) (10-Thoroughly)

**13.**

**A) How much does this tool engage with client/patient strengths and values?**

(1- Not at all) (2) (3) (4) (5) (6) (7) (8) (9) (10-Thoroughly)

**B) This tool should engage with client/patient strengths and values:**

(MORE) (AS IS) (LESS) (NOT AT ALL)

**14.**

**A) How much does this tool engage with client/patient problems and deficits?**

(1- Not at all) (2) (3) (4) (5) (6) (7) (8) (9) (10-Thoroughly)

**B) This tool should engage with client/patient problems and deficits:**

(MORE) (AS IS) (LESS) (NOT AT ALL)

*The following 2 questions ask you to rank how much this tool engages with client/patient health.*

**15.**

**A) On a scale from 1-10, how much does this tool engage with client/patient Mental Health?**

(1- Not at all) (2) (3) (4) (5) (6) (7) (8) (9) (10-Thoroughly)

**B) This tool should address this issue:** (MORE) (AS IS) (LESS) (NOT AT ALL)

**16.**

**A) On a scale from 1-10, how much does this tool engage with client/patient Physical Health?**

(1- Not at all) (2) (3) (4) (5) (6) (7) (8) (9) (10- Thoroughly)

**B) This tool should address this issue:** (MORE) (AS IS) (LESS) (NOT AT ALL)

*The following 10 questions ask you to rank how much this tool engages with issues that may be relevant to client/patient health.*

**17.**

**A) On a scale from 1-10, how much does this tool engage with client/patient Substance Use?**

(1- Not at all) (2) (3) (4) (5) (6) (7) (8) (9) (10- Thoroughly)

**B) This tool should address this issue:** (MORE) (AS IS) (LESS) (NOT AT ALL)

**18.**

**A) On a scale from 1-10, how much does this tool engage with client/patient Trauma?**

(1- Not at all) (2) (3) (4) (5) (6) (7) (8) (9) (10- Thoroughly)

**B) This tool should address this issue:** (MORE) (AS IS) (LESS) (NOT AT ALL)

**19.**

**A) On a scale from 1-10, how much does this tool engage with client/patient Suicidality?**

(1- Not at all) (2) (3) (4) (5) (6) (7) (8) (9) (10- Thoroughly)

**B) This tool should address this issue:** (MORE) (AS IS) (LESS) (NOT AT ALL)

**20.**

**A) On a scale from 1-10, how much does this tool engage with client/patient Self Harm?**

(1- Not at all) (2) (3) (4) (5) (6) (7) (8) (9) (10- Thoroughly)

**B) This tool should address this issue:** (MORE) (AS IS) (LESS) (NOT AT ALL)

**21.**

**A) On a scale from 1-10, how much does this tool engage with client/patient Gender?**

(1- Not at all) (2) (3) (4) (5) (6) (7) (8) (9) (10- Thoroughly)

**B) This tool should address this issue:** (MORE) (AS IS) (LESS) (NOT AT ALL)

**22.**

**A) On a scale from 1-10, how much does this tool engage with client/patient Sexuality?**

(1- Not at all) (2) (3) (4) (5) (6) (7) (8) (9) (10- Thoroughly)

**B) This tool should address this issue:** (MORE) (AS IS) (LESS) (NOT AT ALL)

**23.**

**A) On a scale from 1-10, how much does this tool engage with client/patient Racial Identity?**

(1- Not at all) (2) (3) (4) (5) (6) (7) (8) (9) (10- Thoroughly)

**B) This tool should address this issue:** (MORE) (AS IS) (LESS) (NOT AT ALL)

24.

**A) On a scale from 1-10, how much does this tool engage with client/patient Employment?**

(1- Not at all) (2) (3) (4) (5) (6) (7) (8) (9) (10- Thoroughly)

**B) This tool should address this issue:** (MORE) (AS IS) (LESS) (NOT AT ALL)

25.

**A) On a scale from 1-10, how much does this tool engage with client/patient Housing?**

(1- Not at all) (2) (3) (4) (5) (6) (7) (8) (9) (10- Thoroughly)

**B) This tool should address this issue:** (MORE) (AS IS) (LESS) (NOT AT ALL)

26.

**A) On a scale from 1-10, how much does this tool engage with client/patient Finances?**

(1- Not at all) (2) (3) (4) (5) (6) (7) (8) (9) (10- Thoroughly)

**B) This tool should address this issue:** (MORE) (AS IS) (LESS) (NOT AT ALL)

27.

**A) On a scale from 1-10, how much does this tool engage with client/patient Social Supports (i.e. family & friends)?**

(1- Not at all) (2) (3) (4) (5) (6) (7) (8) (9) (10- Thoroughly)

**B) This tool should address this issue:** (MORE) (AS IS) (LESS) (NOT AT ALL)

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**Appendix B**

**HiREB Approval**



Jun-15-2021

**Project Number:** 13228

**Project Title:** Investigating the Content and Efficacy of Mental Health Assessment Tools

**Student Principal Investigator:**

**Local Principal Investigator:** Dr. Ann Fudge Schormans

We have completed our review of your study and are please to issue our final approval.

You may now begin your study. The following documents have been approved on both ethical and scientific grounds:

Document Name	Document Date	Document Version
CLEAN COPY HiREB Protocol Description	Jun-04-2021	2
CLEAN COPY ICEMHAT Recruitment Script	Jun-04-2021	2
CLEAN COPY Thesis Survey Draft Vincent Farrauto 001145716	Jun-04-2021	2
CLEAN COPY Letter of Information and Consent 001145716.docx	Jun-04-2021	2

The following documents have been acknowledged:

Document Name	Document Date	Document Version
HiREB Summary of Changes	Jun-04-2021	1
tcps2_core_certificate	Aug-21-2014	1

In light of the current COVID-19 pandemic, while this study has been reviewed by HiREB and given final approval status, the actual conduct of the research needs to be performed in accordance with institutional restrictions with respect to Coronavirus (which may mean new participants cannot be actively enrolled and most research staff will be limited with respect to access to other data sources for the time being).

Any changes to this study must be submitted with an Amendment Request Form before they can be implemented.

This approval is effective for 12 months from the date of this letter. Upon completion of your study please submit a **Study Completion Form**.

If you require more time to complete your study, you must request an extension in writing before this approval expires. Please submit an **Annual Review Form** with your request.

PLEASE QUOTE THE ABOVE REFERENCED PROJECT NUMBER ON ALL FUTURE CORRESPONDENCE

Good luck with your research,



Kristina Trim, PhD, RSW  
 Chair,  
 HiREB  
 Student  
 Research  
 Committe  
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The Hamilton Integrated Research Ethics Board (HiREB) represents the institutions of Hamilton Health Sciences, St. Joseph's Healthcare Hamilton

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## **Appendix C**

### **Letter of Information and Consent**

#### **LETTER OF INFORMATION / CONSENT**

**Study Title: Investigating the Content and Efficacy of Mental Health Assessment Tools**

#### **Investigators:**

##### **Local Principal Investigator:**

Dr. Ann Fudge Schormans  
Department of Social Work  
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##### **Student Investigator:**

Vincent Farrauto  
Department of Social Work  
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#### **Purpose of the Study**

I am trying to discover if there are insufficiencies regarding the content within tools used by health professionals to assess people with mental health issues. Health professionals use many tools to assess mental health issues, and I want to study their experience and insight with these tools. I am doing this research for my masters thesis in order to receive my Master of Social Work Degree.

You are invited to take part in this study on the utilization of assessment forms meant to assess people with mental health issues. Participation in the study involves completion of a short online and anonymous survey. In studying your responses to the survey questions, I am hoping to learn about healthcare workers' opinions of the use of such tools. I hope to find out if healthcare workers think that assessment tools should be revised, removed, combined with other tools, or kept as they are.

### Procedures involved in the Research

These surveys will be completed online voluntarily and anonymously. The email within which you have accessed this Letter of Information will have a Limesurvey link to the survey. This same link can also be found at the bottom of this document.

This survey includes questions about the following:

- your use of an assessment tool in assisting people with mental health issues
- your opinions about aspects of this tool
- general information about your job title and responsibilities
- 

This survey will take approximately 10 minutes to complete. This survey is being sent to St. Joseph's Staff members who work directly with people who have, or are thought to have mental health issues. Because it is an online survey, you can complete it at a time that is convenient for you, and from a location of your choice. Below is a sample of some questions you will be asked in the survey.

1. *What is your role? Social Worker, Nurse, Occupational Therapist, Other: \_\_\_\_\_*
2. *What assessment tool do you use most often? \_\_\_\_\_*
3. *On a scale from 1-10, how much does this tool engage with Mental Health?  
(1- Not at all) (2) (3) (4) (5) (6) (7) (8) (9) (10-Thoroughly)*
4. *How important is it for you to build rapport with a client/patient while you are using this tool?  
(1- Not important) (2) (3) (4) (5) (6) (7) (8) (9) (10-Essential)*
5. *On average, how much time do you have to complete this tool with a client/patient? \_\_\_\_\_ Minutes.*

### Potential Harms, Risks or Discomforts:

This is an anonymous survey, and no identifying information is being collected. The risks involved in participating in this study are minimal. You may feel uncomfortable with sharing your opinion about the tools that you use at work. You may find it stressful to consider how these tools influence your work and the service you provide to clients/patients.

Please note that if you choose to participate, you may stop at any time to take a break, you do not need to answer any questions that you do not wish to answer, and you can withdraw (stop taking part) at any time prior to submitting your completed survey. I describe below the steps I am taking to protect your privacy.

### Potential Benefits



It is unlikely there will be any direct benefits to you. This research may help to provide insight into the current utilization of assessment tools for mental health, including arguments for tools to be revised, removed, or left unchanged. This research may be used in decisions to change assessment tools.

I hope that what is learned as a result of this study will help us to better understand what is most essential in assessment tools meant to assist people with mental health issues.

### **Confidentiality**

As noted, you are participating in this research anonymously - no identifying information is being collected through the survey questions. No one at St. Joseph's Healthcare Hamilton, at McMaster University, or myself will know that you have participated. You are not required to respond to myself or Jimenna Silliker if you want to remain anonymous for the study.

The information/data you provide will be kept on my password protected computer and will be further encrypted within Limesurvey's Sodium Library software. It will also be stored on McMaster's secure drive through my student account. Once the study is complete, the data will be deleted from these places of storage.

### **Participation and Withdrawal**

Your participation in this study is voluntary. It is your choice to be part of the study or not. If you decide to be part of the study, you can decide to stop at any time prior to submitting the survey. Because it is an anonymous survey, there will be no way for me to know which survey was yours if you wanted to withdraw it after having submitted it. If you decide to withdraw before submitting the survey, there will be no consequences to you. Your decision whether or not to be part of the study will not affect your employment with St. Joseph's Healthcare Hamilton.

### **Information about the Study Results**

I expect to have this study completed by approximately early August 2021. The results will be included in my research thesis which will be posted online at McMaster University's library system after successful completion of my thesis (approximately Sept. 30, 2021).

### **Questions about the Study**

If you have questions or need more information about the study itself, please contact me at: [farrauvs@mcmaster.ca](mailto:farrauvs@mcmaster.ca)

You may also contact my supervisor at: [fschorm@mcmaster.ca](mailto:fschorm@mcmaster.ca)

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HiREB). The HiREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the Chair, HiREB, at 905.521.2100 x 42013.

### CONSENT STATEMENT

Having read the information above, I understand that by clicking on the survey link below, and by completing and submitting the survey, I have agreed to take part in this study. I agree also to allow my study data to be stored as described above.

[Lime survey Link]



## Appendix D

### Protocol Description

#### ICEMHAT Protocol Description

**Study Title:** Investigating the Content and Efficacy of Mental Health Assessment Tools

#### **Investigators:**

**Local Principal Investigator:**  
 Dr. Ann Fudge Schormans  
 Department of Social Work  
 McMaster University  
 Hamilton, ON, Canada  
 (905) 525-9140 ext. 23790  
 E-mail: (fschorm@mcmaster.ca)

**Student Investigator:**  
 Vincent Farrauto  
 Department of Social Work  
 McMaster University  
 Hamilton, ON, Canada  
 Phone: 289-###-####  
 E-mail: (farrauvs@mcmaster.ca)

#### **Study purpose and rationale**

Concerns have been raised as to the ability of current mental health assessment and scaling tools to account for issues beyond the psychological, to give adequate consideration to physical or social aspects of patients' illnesses (McQuaid, Marx, Rosen, Bufka, Tenhula, Cook, & Keane, 2012). Of further concern is that there may be inconsistencies between the different assessment tools with regard to the content they cover (Newson, Hunter, & Thiagarajan, 2020). Additionally, current mental health assessment tools may insufficiently engage with the strengths, values, and goals of service users which may have a negative impact on treatment selection and outcome (Wand, Buchanan, Derrick, & Harris, 2020). In this study, I will be exploring, through the use of a survey, the perspectives of health professionals at St. Joseph's Healthcare Hamilton who use these tools in their health care practice as to their effectiveness, usefulness, and needs for improvement in their work with people with mental health issues.

### **Description of the population to be studied, inclusion and exclusion criteria**

The population to be studied are St. Joseph's Healthcare Hamilton professionals who utilize assessment tools to assist clients with mental health issues. Professionals who either do not use assessment tools, and/or do not work with people with mental health issues are excluded from this study. There are no exclusion criteria based on gender or race.

### **Sample size (and how sample size was determined)**

This study is being completed as part of my Master of Social Work degree. This is a time limited program (12 months) and research follows course work. Due to these time constraints, I will be using a convenience sample focused exclusively on health care workers at St. Joseph's Healthcare Hamilton who use assessment tools to assist people with mental health issues. I expect the sample size to be between 10-30 people, based on St. Joseph's Healthcare Hamilton employees' availability and willingness to complete the survey during the Covid-19 pandemic.

### **Design and detailed description of methodology**

Planned is a quantitative survey using McMaster University's Lime Survey tool. I plan to ask healthcare workers how they feel about the assessment tools they are using when assessing mental health of the patients they work with, to determine their feelings as to effectiveness, usefulness and needs for improvement of these tools. **I am using a survey for data collection as it allows for greater flexibility for healthcare workers to dedicate time to complete it, and will ask less time of them than a qualitative interview (Bruce, Pope, & Stanistreet, 2008).** Potential participants will complete a relatively short and anonymous survey consisting of multiple choice and scaling questions.

### **Definition of end-point(s)**

Data collection will begin upon receipt of ethical clearance and end approximately July 15th, 2021. Data analysis will be ongoing as surveys are received, with an anticipated end date of July 30th, 2021.

### **Measurements, measurement instruments, and data analysis plan**

This survey consists of 25 multiple choice and scaling questions. I plan to analyze the data first using descriptive statistics to look at the frequency of responses to each question. Informed by critical theory and engagement with the relevant research literature, I will further analyze the data as to the alignment between participants' responses.

### **How subjects will be recruited, including advertisements/publicity**

To recruit research participants, Jimena Silliker has agreed to distribute the recruitment materials (email script and letter of information/consent form) on my behalf via email to healthcare workers who are currently using mental health assessment tools in their practice. As the survey is anonymous, neither myself or Jimena will know who chose to participate (or not) in the study. Jimena will email appropriate health care workers at these three St. Joseph's Healthcare Hamilton sites: Charlton Campus, King Campus, and West 5th Campus.

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## **Appendix E**

### **Recruitment Script**

**Vincent Farrauto BSW**

**Masters Candidate in Social Work**

**Study Title:**

**Investigating the Content and Efficacy of Mental Health Assessment Tools**

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**E-mail Subject line:** Study about assessment tool content and efficacy.

Dear Employees,

Vincent Farrauto, a McMaster student, has contacted St. Joseph's Healthcare Hamilton (SJHH) asking us to tell our employees about a study he is doing on assessment form use in the workplace. This research is part of his Master of Social Work program at McMaster University.

If you are interested in getting more information about taking part in Vincent's study please read the brief description below and/or **contact Vincent Farrauto directly** by using his McMaster email address [Farrauvs@mcmaster.ca](mailto:Farrauvs@mcmaster.ca) . The researcher will not tell me or anyone at St. Joseph's Healthcare Hamilton who participated or not. Taking part or not taking part in this study will not affect your status or any services you receive here at SJHH. You are not required to respond to myself or Vincent Farrauto if you want to remain anonymous for the study.

Vincent Farrauto is inviting you to complete a short survey about the utilization of assessment tools meant to assess people with mental health issues. As a health professional, you may use these tools to assess people with mental health issues, and he wants to learn about your experience and insights regarding the use of these tools. In studying your responses, he is hoping to find out if healthcare workers think that assessment tools should be revised, removed, combined with other tools, or kept as they are.

Mr. Farrauto has explained that the survey is anonymous and that you can stop being in the study at any time prior to your submission of the filled survey. He has asked us to attach a copy of his information letter to this email. That letter gives you full details about his study.

In addition, this study has been reviewed by the Hamilton Integrated Research Ethics Board. If you have questions or concerns about your rights as a participant or about the way the study is being conducted, you may contact:

Office of the Chair

Telephone: (905) 521-2100 ext. 42013

Sincerely,

Jimena Silliker, MSW., RSW

Manager, Dept of Social Work (Charlton)

Professional Practice Lead, Social Work

Interim Manager, Satellite Health Facility

St. Joseph's Healthcare Hamilton

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